SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Friday, 11 January, 2013

10.00 am

Darent Room, Sessions House, County Hall, Maidstone

AGENDA

SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Friday, 11 January 2013, at 10.00 am
Darent Room, Sessions House, County Hall, Maidstone

Ask for: **Theresa Grayell**
Telephone: **01622 694277**

Tea/Coffee will be available 15 minutes before the start of the meeting

Membership (13)

Conservative (11): Mr C P Smith (Chairman), Mrs A D Allen (Vice-Chairman), Mr R E Brookbank, Mr N J D Chard, Mrs V J Dagger, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby, Mr P W A Lake and Mr A T Willicombe

Liberal Democrat (1): Mr S J G Koowaree

Labour (1) Mr L Christie

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UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

The Chairman will assume that all Members will read the reports before attending the meeting. Officers are asked to assume the same when introducing reports.

A. COMMITTEE BUSINESS

A1 Introduction/Webcast Announcement

A2 Substitutes

A3 Declarations of Members' Interest in items on today's Agenda

A4 Minutes of the Meeting held on 9 November 2012 (Pages 1 - 12)

A5 FOR INFORMATION - Minutes of the Meeting of the Corporate Parenting Panel held on 26 October 2012 (Pages 13 - 18)

The Cabinet Committee asked to see Minutes of the Corporate Parenting Panel as an information item at each meeting. The Minutes of the Panel's December meeting are not yet ready to share, but the cleared minutes of the 26 October meeting are included this time.

A6 Chairman's Announcements

B. ITEMS RELATING TO ADULT SOCIAL CARE

B1 Oral Updates by Cabinet Member and Director

Key or Significant Cabinet or Cabinet Member Decision/s for Recommendation or Endorsement

B2 12/01981 - Kent County Council's Annual Report (Local Account) on Adult Social Care for April 2011 to March 2012 (Decision to be taken by the Cabinet Member for Adult Social Care and Public Health) (Pages 19 - 44)

C. ITEMS RELATING TO SPECIALIST CHILDREN'S SERVICES

C1 Oral Updates by Cabinet Member and Director

C2 Short Breaks for Disabled Children (Pages 45 - 50)

D. ITEMS RELATING TO PUBLIC HEALTH

D1 Oral Updates by Cabinet Member and Director

E. PERFORMANCE MONITORING ITEMS

E1 Families and Social Care Directorate Financial Monitoring 2012/13 (Pages 51 - 100)

E2 Families and Social Care Performance Dashboard for October 2012 (Pages 101 - 124)

E3 Children's Services Improvement Plan: Progress Update (Pages 125 - 132)

E4 Health Improvement Programmes Performance Report (Pages 133 - 136)

E5 Kent and Medway Safeguarding Vulnerable Adults Annual Report April 2011 - March 2012 (Pages 137 - 182)

E6 Dementia - A New Stage In Life: Select Committee One Year On Report (Pages 183 - 198)

E7 CAMHS update (Pages 199 - 210)

F. OTHER ITEMS FOR COMMENT OR RECOMMENDATION TO THE LEADER, CABINET, CABINET MEMBER/S OR OFFICERS

F1 2013/14 Final Draft Budget (Pages 211 - 232)

F2 Business Planning 2013/14 - Draft Plans (FSC) (Pages 233 - 364)

F3 Business Planning 2013/14 - Draft Plans (PH) (Pages 365 - 394)

F4 Public Health 23 Programmes (Pages 395 - 456)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services
(01622) 694002

Thursday, 3 January 2013

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KENT COUNTY COUNCIL

SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Social Care and Public Health Cabinet Committee held in the Darent Room, Sessions House, County Hall, Maidstone on Friday, 9 November 2012.

PRESENT: Mr C P Smith (Chairman), Mrs A D Allen (Vice-Chairman), Mr R E Brookbank, Mr N J D Chard, Mr L Christie, Mr K A Ferrin, MBE, Mr C Hibberd, Mr M J Jarvis, Mr J D Kirby, Mr S J G Koowaree, Mr P W A Lake and Mr A T Willicombe

ALSO PRESENT: Mr G K Gibbens and Mrs J Whittle

IN ATTENDANCE: Mr A Ireland (Corporate Director, Families and Social Care), Ms M Peachey (Kent Director Of Public Health), Mr M Lobban (Director of Strategic Commissioning), Ms M MacNeil (Director, Specialist Children's Services), Mr A Scott-Clark (Director of Health Improvement (KCC), NHS Kent and Medway), Ms P Southern (Director of Learning Disability and Mental Health), Mrs A Tidmarsh (Director of Older People and Physical Disability) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

45. Minutes of the Meeting held on 14 September 2012

(Item A4)

1. Two corrections were made to the minutes, as follows:-

   Minute 30, para 2. b) - the figures for the number of Foster Carers and the number of children being cared for have been transposed. They should read '800 Foster Carers caring for 1,150 children'.

   Minute 41, para 2 – the date of the Pilkington case should read '2007'.

2. RESOLVED that, subject to the amendments set out above, the minutes of the meeting held on 14 September are correctly recorded and they be signed by the Chairman. There were no matters arising.

46. Oral Updates by Cabinet Member and Director

(Item B1)

1. Mr Gibbens gave an oral update on the following issues:-

   - ***Attended Official Opening of Age UK Maidstone New Offices on 27 September*** – the opening of these new offices shows that Age UK are adapting and responding to changing needs
   - ***Attended and spoke at Northgate Ward Celebration Event on 17 October,*** where the KCC Chairman Opened the Learning Disability Suite

- ***Attended the National Children and Adult Services Conference 2012 on 24 and 25 October in Eastbourne***, at which the Health Minister Norman Lamb praised KCC's personalisation agenda. Congratulations to the officer team which developed this.

2. Mr Ireland then gave an oral update on the following issues:-

- ***Transformation programme*** – the first evidence of change in services arising from NHS 'invest to save' money is now visible, and will have impact on admission and discharge patterns and types of care accessed. 'Invest to Save' money sits within the NHS but is committed to local government. Some local authorities use it to bail out or shore up other services, while others use it to broaden the range of services offered.
- ***Telecare conference*** – this was well attended and will help spread the message to a wider audience and move issues forward. Analysis of patterns of use is being undertaken in partnership with an external provider.

47. 12/01858 - Outcome of Formal Consultation to re-provide Services for People with a Physical Disability using The Bridge Resource Centre, Hythe (Decision to be taken by the Cabinet Member for Adult Social Care and Public Health)
(Item B2)

1. Mrs Tidmarsh introduced the report and responded to comments and questions from Members. The following points were highlighted:-

a) the proposed changes have not yet been made and are not a *fait accompli,* so, if it is minded to, the Committee still has the opportunity to recommend that they not be made;

b) the proposed changes represent only an interim position; buildings are to be refurbished, not closed, and the present users catered for temporarily in a different facility at the same site;

c) most responses to the consultation which had come from service users and their carers had expressed a wish for the current group to remain together. Only one person chose to move to a different centre which is nearer their home and offers a different type of service;

d) all KCC Members who represent service users affected by the proposals had been invited by the Cabinet Member, Mr Gibbens, to a consultation session;

e) the proposals had been very well thought through, with account being taken of the difficulty some vulnerable service users have in coping with change;

f) charges made for sessions are means tested and based on service users' income, and many pay less than the maximum cost of £28 per day session. Most service users provide their own transport; and

g) the process of modernising day opportunities (for example, those for people with learning disabilities) has developed and been much improved since earlier changes, with lessons being learnt from each successive experience.

2. Mr Gibbens thanked Members for their comments. He reassured the Committee that he personally briefs Local Members about such changes when they are proposed. He added that one person had attended a consultation meeting and had been supportive of the proposed changes.

3. RESOLVED that the decision proposed to be taken by the Cabinet Member for Adult Social Care and Public Health, to take forward the re-provision of services for people with a physical disability at The Bridge Resource Centre at Hythe, using alternate providers or a direct payment, be endorsed.

48. 12/01981- Kent County Council's Annual Report (Local Account) on Adult Social Care for April 2011 to March 2012 (Decision to be taken by the Cabinet Member for Adult Social Care and Public Health)
(Item B3)

Mr M Thomas-Sam, Strategic Business Advisor, was in attendance for this item.

1. Mr Thomas-Sam introduced the report and explained that the intended timetable for the document is that it should be completed following the November Cabinet Committee meeting and then signed off by the Cabinet Member in December. Therefore, the November meeting is the only chance that this Committee would have of commenting on its content. He responded to comments and questions from Members and the following points were highlighted:-

a) although some specific questions of detail were answered, Members asserted that the document in its current state is inadequate and not fit for purpose as it lacks comparative data and contains data errors, reporting of information in which they were not happy with the emphasis and gaps where further information or material has yet to be added. Although it had obviously been intended as a working draft for their comments, Members were not confident of agreeing a document, the content of which may then change considerably, without having a further opportunity to discuss it formally;

b) Members considered it more important that the document be complete, accurate and reliable and that they could be proud of it than it be signed off within the planned timetable. There was consensus that the document was not yet ready to be signed off; and

c) Members commented that the document also serves to help the general public understand the County Council's work, so needs to be transparent and easy to understand. An 'easy-read' précis version could be produced.

2. The Cabinet Member, Mr Gibbens, thanked Members for their comments and assured them that he would take account of them before signing off the document. He said he was happy to meet with any Member who had outstanding concerns,

following the Cabinet Committee meeting, and proposed that a cross-party working group be convened to develop and discuss an updated version of the document.

3. Mr N J D Chard proposed and Mr L Christie seconded that an updated and completed version of the Local Account document be re-submitted to this Committee's January meeting for Members' consideration, ahead of it being formally signed off by the Cabinet Member.

Agreed without a vote

4. The Chairman added that a working group could also discuss and develop the document before the January Cabinet Committee meeting, but there was general consensus that it was the proper role of the Cabinet Committee and not a working group to approve such a document. *All Cabinet Committee Members were subsequently invited to attend a briefing and discussion of the draft document on 3 December at 2.00 pm.*

5. RESOLVED that an updated version of the Local Account document, having due regard to Members' comments set out above, be re-submitted to this Committee's January meeting for Members' consideration, ahead of it being formally signed off by the Cabinet Member.

49. Oral Updates by Cabinet Member and Director
(Item C1)

1. Mrs Whittle gave an oral update on the following issues:-

- ***Peer Review follow up*** – focus now needs to be on three key aims: the child's journey, the constant need to recruit more adopters, and reducing drift and delay. A pack of papers will be put together for the Adoption Summit and will be shared with all Members.
- ***Adoption Summit 4 December*** – a letter about this will be sent to all Members.
- ***National Adoption Week 5 – 9 November***
- ***Adoption figures for the year so far*** – Since April 2012:-
  71 children have been placed for adoption, compared to 68 children in the same period in 2011/12. The aim is to place 100 – 120 children by the end of this financial year. Over 50% of children awaiting placement are siblings, and over 30% are aged over 5.
  55 Adoption Orders have been made. It takes nine months between a child being placed for adoption and an Adoption Order being made.
  40 Adopters have been recruited, compared to 57 in the same period in 2011/12.

2. Mr Ireland then gave an oral update on the following issues:-

- ***Peer Safeguarding Review*** – the final written version of the assessment is due soon. The review team had been very impressed with Kent staff, and deep dive reviews of performance have shown good outcomes from the review and evidence of determination to continue progress. Staff and management briefings have been held to take forward key issues, and District Managers have done much work, but there is still much to do. The Chairman of the KSCB is taking an active role.

- ***Implementation of new structure*** – the new structure is now in place and staff feel positive about the changes (as shown in deep dive reviews)
- ***Children in Care conference*** – KCC staff participated. The engagement of young people was highlighted as a key issue.

3. Mrs Whittle, Mr Ireland and Ms MacNeil responded to comments and questions from Members and the following points were highlighted:-

a) some children are difficult to place for adoption and may never be adopted. What work goes on to help the most vulnerable children? *KCC is committed to finding the right package of support for each child, based on their individual needs, and every case is different. It is vital to get the support right*;

b) would the age range of adopters be extended to help increase the numbers? *KCC is open minded in attracting a diverse resource of adopters, including a range of ages, but clearly it is practical to set an upper age limit so adopters can be confident of seeing a child through to adulthood;*

c) how do issues raised by the Reer Review relate to those raised by the Parliamentary Select Committee, eg the allegation that Kent gives only good news to Members, and the suggestion that more children should be taken into care? *The Select Committee alleged that local authorities miss some neglect cases and should take more children into care. Outcomes of being in care are generally poor but early intervention and preventative services can address issues. It is important to check that intervention is happening at the right stage. Issues in Kent are dealt with in as open and transparent a manner as possible. The issue of giving only good news to Members was raised with the Select Committee and the allegation was then deleted from a later draft of the formal review letter. A report on the Parliamentary Select Committee's findings will be made to the Corporate Parenting Panel in the new year; and*

d) one issue not covered in Adoption debates is that taking young people into care does not necessarily make them safer. Coverage of outcomes of being in care should always be included, as these are not usually good. The issue of deciding when best to take a child into care is always a dilemma.

50. DfE Consultation "Adoption and Fostering - Tackling Delay"
(Item C2)

Ms M Lowe, Performance and Quality Assurance Officer, Children in Care, was in attendance for this item.

Mr Kirby declared an interest as a Member of the West Kent Adoption Panel.

Mr Koowaree declared an interest as the Grandparent of a child who is in the care of the County Council.

1. Ms Lowe introduced the report and explained that the draft response to be sent from the County Council was presented in the report for Members' comments. Ms Lowe, Ms MacNeil, Mrs Whittle and Mr Ireland responded to comments and questions from Members and the following points were highlighted:-

a) parts of the draft response contradict each other around the suggested maximum size of an adoption panel, stating in one place '6 Members with a quorum of 4' and in another '8 Members with a quorum of 5'. The view the KCC wishes to give will need to be clarified before submission;

b) delegation of various responsibilities to Foster Carers will depend on the circumstances of the child concerned. If they are in care voluntarily (under Section 20 of the Children Act 1989), the County Council would not delegate responsibility in the same way as if the child had been placed in care following care proceedings (Section 31). The Council's aim is always to make life as 'normal' as possible for a fostered child;

c) with regard to an age limit for Foster Carers or Adopters, it is not so much the carer's age that is important but their ability to nurture and care for a child and meet the child's needs. Matching a carer to a child is most important, and the carer's age does not necessarily affect a decision to place a child;

d) openness and transparency are vital in helping the public to understand how the Council undertakes its fostering and adoption duties and the issues that social workers deal with;

e) the draft response makes no reference to the legal process. Mrs Whittle said it is important to be open and transparent about the Courts process and the delays which are experienced. Coram had expressed surprise at the level of parental challenge that Kent's Courts allow and the delays that this causes. Transparency would be helped if Courts were to publish figures for the number of cases heard and the length of time each case took to be resolved. Mrs Whittle serves on a Courts Working Group with representatives of the Judiciary and other stakeholders, and this is an ideal place to tackle such issues;

f) Coram will respond separately to the consultation, and it will be interesting to see their views when these and all other responses become public later in the process;

g) the priority should be finding Foster Carers for children, never the other way round;

h) openness with Foster Carers who are deemed unsuitable after KCC received covert evidence about them is important but there needs to be a balance between openness and discretion in what Foster Carers are told;

i) Members who serve on Adoption Panels challenged the concern, expressed in the Department of Education's document, that large

Panels can lead to delays, and said that, in their experience, delays most often arise from poor standards of reporting. Reporting needs to be good to make best use of Panels' time;

j) a view was expressed that, as Corporate Parents, KCC Members should serve on Adoption Panels as this complements their Corporate Parenting role; and

k) the process that prospective adopters go through should be simplified to make it less onerous and oppressive for them.

2. RESOLVED that the draft response to be sent from the County Council be endorsed, having regard to Members' comments set out above and with the addition of a paragraph about transparency and openness around Courts delays.

51. Oral Updates by Cabinet Member and Director
(Item D1)

1. Mr Gibbens gave an oral update on the following issues:-

- ***Public Health Briefing for Members – 6 November***
- ***Kent Sexual Health Services Information Sharing Event - 26 September***
- ***Spoke at Health Inequalities Session*** with Chris Bentley and Gravesham Borough Council on 11 October. It is estimated that every £1 invested in tackling health inequalities generates £11 in savings.
- ***Due to attend Kent Stop Smoking Service Annual Conference 2012 on 26 November***
- ***Raised with Ministers concerns about Public Health funding after 1 April 2013***

2. Ms Peachey then gave an oral update on the following issues:-

- ***Public Health Transition:***
  - ***Budget*** – there was previously no budget but now £300,000 has been allocated by the Department of Health
  - ***Staff*** – a joint NHS/KCC staff away day was held to talk about what Public Health might look like in 18 months' time. Input was very positive, and comments will help build plans to move the transition forward
  - ***Public Health England*** – this now has its Chief Executive and senior staff team in place and will increase in importance from her on. Its key issues to look at are immunisation and screening, and via its involvement in the National Commissioning Board it can build on past success
  - ***Public Health Emergency Planning***
- ***Sexual Health Services – Developments in West Kent*** – a decision on this will be needed by April 2013. It's a big area of work with a £12m budget with which to contract services.
- ***Media coverage of young people and alcohol issues*** – the use of drugs and alcohol by under-18s has recently had media coverage.

- ***Smoking in Pregnancy*** – a budget of £100,000 has been allocated for motivational work with pregnant women, as 80% of deaths from SIDS (Sudden Infant Death Syndrome) are due to mothers smoking during pregnancy.

3. Mr Gibbens, Ms Peachey and Mr Scott-Clark responded to comments and questions from Members and the following points were highlighted:-

a) a view was expressed that having a performance target for the number of people encouraged to give up smoking conflicts with the fact that some KCC staff pension funds are invested in tobacco companies;

b) surely those who want to quit smoking already have, and there are only the most committed left to persuade? *Public Health research shows that 50% of smokers do want to give up but they often take several attempts to achieve it. There are strong links between deprivation and addiction of various kinds. Many young people still seem to view smoking as cool;*

c) is a stricter alcohol ban in public places needed, to reduce the places where young people can drink? *Different approaches will work in different locations, for example Gravesham have an alcohol-free town centre policy which seems to be working well;*

d) would external consultants for campaign work be paid for by Public Health or the Families and Social Care budget? *It would be covered by the Public Health budget;*

e) Members challenged the assertion that no safe drinking is possible for under-18s. It is legal to drink wine in restaurants at 16, and parents can allow very tightly controlled alcohol consumption at home. Parents need to educate and inform teens so they understand and respect alcohol and its effects;

f) there followed a debate about the value of an educational approach to address under-age drinking. The 21 age limit works in the USA as it is strictly enforced, but identity cards are too easy to forge. Enforcement around the supply of alcohol, for example in pubs and clubs, is the only effective way to change behaviour in the UK; and

g) the KCC Select Committee on Alcohol Misuse, which produced its report in 2008, could be revisited.

52. Families and Social Care Directorate Financial Monitoring 2012/13
(Item E1)

Mr D Shipton, Head of Financial Strategy, was in attendance for this item.

1. Mr Shipton introduced the report and, with Mrs Tidmarsh, Ms MacNeil and Mr Ireland, responded to comments and questions from Members. The following points were highlighted:-

a) predicting the need for, and likely take-up of, Direct Payments is difficult, partly because their use tends to highlight unmet needs and prompts service users to re-think the services they want to access and how they want to access them. This unknown quantity has an impact across all services. Members were assured, as they have been previously, that no-one is compelled to switch to a Direct Payment against their will;

b) the KCC has a brokerage role in helping service users to manage their Direct Payments, and this requires staff to give a different sort of support. As people move away from traditional service provision, the level of staff support needed for this is reduced; and

b) the short breaks respite scheme for families with disabled children shows an underspend due to low take-up, but the reasons for this would need to be investigated. Members asked to have more information about the scheme, and it was agreed that a report setting out more detail be prepared for this Committee's January meeting. This should include the take-up rate and reasons for the current underspend in this area, a summary of what the offer covers and an assessment of the effectiveness of the promotion of the scheme to reach those families who most need it.

2. RESOLVED that:-

a) the information set out in the report and given in response to questions be noted, with thanks; and

b) a report setting out more detail of the short breaks respite scheme for families with disabled children be prepared for this Committee's January meeting. This should include the take-up rate and reasons for the current underspend in this area, a summary of what the offer covers and an assessment of the effectiveness of the promotion of the scheme to reach those families who most need it.

53. Families and Social Care Performance Dashboard for September 2012 and Business Plan Mid-Year Summary
(Item E2)

Mrs S Abbott, Head of Performance and Information Management, and Mr J Smith, Management Information Officer, were in attendance for this item.

1. Mrs Abbott introduced the report and Ms MacNeil and Mr Ireland responded to comments and questions from Members. The following points were highlighted:-

a) the report shows that a total of 7 looked after children were not allocated a social worker. This was because three agency social workers had left suddenly without warning, so on a particular day those young people were left without an allocated worker. The situation was rectified very soon after by their cases being re-allocated, so they were without a social worker for only a very short time. Members were assured that it is highly unusual for agency workers to leave without

notice in this way and this situation is not one with which the KCC would usually expect to have to deal;

b) the Child Protection Plan process allows children who have previously had a Plan to have it re-activated quickly in the event of their family circumstances having deteriorated, and this safety net might account for the rise in the percentage of children being the subject of a Child Protection Plan for a second or subsequent time; and

c) the social worker vacancy rate is currently 12 – 13 % and recruitment of social workers is proceeding steadily. Agency staff do not count as part of permanent staff figures.

2. RESOLVED that the information set out in the report and given in response to questions be noted, with thanks.

54. Business Planning 2013/14: FSC Headline Priorities
(Item E3)

Mr M Thomas-Sam, Strategic Business Advisor, was in attendance for this item.

1. Mr Thomas-Sam introduced the report and explained that headline business planning priorities were being presented earlier this year to allow Members to have early input into the preparation of the draft Business Plan, which would then be discussed at the Committee's January meeting. Mr Thomas-Sam, Mr Gibbens and Mrs Whittle responded to comments and questions from Members and the following points were highlighted:-

a) the divisional business plan for Public Health is listed separately to those of the other divisions as it has a separate management structure and funding, so to keep it separate is appropriate;

b) it is not clear amongst the listings where the CAMHS service fits and what priority it has, and officers undertook to ensure that this is clear in the draft business plan that this Committee will consider in the new year; and

c) updates on the running of the new CAMHS contracts which started on 1 September will be considered the next meetings of both this Committee and the Corporate Parenting Panel. The new contract holders, Oxlees and Sussex NHS Trust, have a challenging backlog of cases to tackle but work is progressing well. Members asked that these updates include details of where the service is being provided from, how accessible these places are for the clients who need to access them, and how well trained the staff are who are delivering services.

2. RESOLVED that:-

a) the information set out in the report and given in response to questions be noted, with thanks; and

b) the priority of the CAMHS service within the draft Business Plan be made clear and details of the CAMHS service requested above be included in a report to this Committee's January meeting.

55. Health Improvement Programme Performance Report
(Item E4)

1. Mr Scott-Clark introduced the report and he and Ms Peachey responded to comments and questions from Members. The following points were highlighted:-

a) the administration and take-up of the flu jab programme each year is a more complex issue than might at first be apparent. As the types of viruses which are most prevalent change from year to year, different client groups might need to be included in the programme (eg pregnant women are more at risk than other groups from new strains of flu virus). For this reason it is difficult to compare like with like from year to year;

b) the Health Check programme focuses on vascular checks to identify hypertension, risk of stroke, etc, and does not include checks such as prostate-specific antigen (PSA). A cost benefit analysis has been carried out for the target group for the vascular checks; and

c) Members expressed disappointment that the Health Checks programme does not extend to people over 74.

2. RESOLVED that the information set out in the report and given in response to questions be noted, with thanks.

56. Public Health Business Planning 2013/14
(Item E5)

RESOLVED that the information set out in the report be noted, with thanks.

57. Consultation on 2013/14 Revenue Budget
(Item F1)

Mr D Shipton, Head of Financial Strategy, was in attendance for this item.

1. Mr Shipton introduced the report and explained that it had been hoped that feedback from the public consultation on the budget could be reported to the November meetings of Cabinet Committees. The consultation had closed on 1 November, the day on which this Committee's papers were published. , As many of the responses had arrived in the final few days, officers had not yet been able to fully analyse the responses in time, and it would be inappropriate to provide Members with a partial analysis. The research report commissioned from Ipsos MORI as part of the consultation process had also not yet been received. The analysis of responses and the MORI report will be presented to Cabinet on 3 December. Cabinet will agree its response and a revised final draft budget will be launched as soon after the provisional grant settlements and details of the new funding arrangements are known. This Committee would then have a full and thorough analysis at its 11 January meeting.

2. Mr Shipton responded to comments and questions from Members and the following points were made:-

a) although only 416 responses to the consultation had been received, this total, although it may seem disappointing, is higher than for previous consultations; and

b) the grant KCC is due to receive to compensate for freezing Council Tax, and this has a substantial impact. Mr Shipton responded that, based on 2012/13 tax base, 1% on Council Tax equates to £5.8m worth of income, but next year this figure will be different due to the new Council Tax benefit arrangements.

3. RESOLVED that the information set out in the report and given in response to questions be noted, with thanks.

KENT COUNTY COUNCIL

CORPORATE PARENTING PANEL

MINUTES of a meeting of the Corporate Parenting Panel held in Darent Room, Sessions House, County Hall, Maidstone on Friday, 26 October 2012.

PRESENT: Mrs A D Allen (Chairman), Mr M J Vye (Vice-Chairman), Mr R E Brookbank, Mrs T Carpenter, Mrs P T Cole, Mr G Cooke, Mrs E Green, Mr P W A Lake, Mr L B Ridings, MBE and Mrs J Whittle

IN ATTENDANCE: Ms M MacNeil (Director, Specialist Children's Services), Mr N Baker (Head of Integrated Youth Services), Mr T Doran (Head Teacher of Looked After Children - VSK) and Miss T A Grayell (Democratic Services Officer)

UNRESTRICTED ITEMS

12. Minutes of the meeting held on 20 September 2012

(Item A2)

RESOLVED that the Minutes of the meeting held on 20 September 2012 are correctly recorded and they be signed by the Chairman. There were no matters arising.

13. Cabinet Member's Oral Update

(Item A4)

1. Mrs Whittle gave an oral update on the following:-

- **Peer Review:** there had been a good debate on this at full Council on 25 October. Much work has been done by Virtual School Kent, and a good vision is coming together to set out the way forward, for which a suggested title is 'Every Day Matters'.
- **A new Children's Minister, Edward Timpson,** was appointed on 4 September. He has similar personal experience of adoption and fostering to the previous Minister, Tim Laughton, so his appointment instils confidence.
- **The National Adults' and Children's Conference** is taking place in Eastbourne this week, 22 – 26 October.
- **Ofsted's written report of its review of Virtual Schools** is now available and was also considered by full Council on 25 October. Virtual School Kent was much praised for its e.PEP (computer-based Personal Education Plan) initiative, in which young people have the opportunity to set their own targets and challenge themselves. There have been mixed reactions to the Ofsted report, for example, the review team did not seem to recognise the scale of Kent's challenge, and still suggests that officers give Members only good news. Mrs Whittle and Mr Ireland plan to write and challenge some of the findings, but in discussion the point was made that the report should be viewed as a whole and its conclusions perhaps seen as an indication of a need to better evidence what Kent does.

2. Mrs Whittle and Ms MacNeil responded to questions and comments from Members and the following points were highlighted:-

- Is the KSCB robust enough now? *Since the peer review, issues at KSCB are being discussed at a higher level than previously, and scrutiny and challenge are more robust. Partners on the Board are working well together.*
- Who chose the venues to be visited by the review team? *Kent sent the review team to see a range of facilities, not just the best, so reviewers would see and report back on a realistic picture. This will avoid a repeat of the shock of getting the previous bad Ofsted report.*
- There was a discussion of the possible role for Locality Boards in challenging on local issues. It would be wise to consider to how many different Boards and groups the same information is reported, as there is potential for much duplication. If Members want information to be reported to Locality Boards this could be done, but not all areas yet have one. Locality Boards could help spread and raise all Members' awareness of their role as Corporate Parents. There would need to be a protocol for contact between local Members and local Managers. Developing roles and a protocol would also help shape the information to be given to newly-elected Members on their Corporate Parenting role. This is a challenging task but one which must be tackled.

3. The oral updates were noted, with thanks.

14. Update regarding the work of the Head Teacher of Virtual School Kent (VSK)
(Item B1)

1. Mr Doran introduced the report and updated Members on key progress since his oral report to the Panel's September 2012 meeting:-

- the academic results reported in September have subsequently been validated
- the written thematic inspection report is now available and will be sent to all Panel Members
- the 'Virtual Voice' website is at the testing stage and it is hoped that this will be launched in November 2012
- excellent feedback about the Olympic-themed rewards ceremony in September has been received from young people and carers who took part
- a very good response to the Assisted Boarding Scheme has been received from Head Teachers and two placements have so far been made, with two more young people currently being assessed for possible placement.

2. Mr Doran, Ms MacNeil and Mrs Whittle responded to comments and questions from Members and the following points were highlighted:-

a) the Assisted Boarding Scheme is still in its early stages and progress has been necessarily cautious as it is important to be absolutely sure that placements are suitable for the young people concerned and will meet their pastoral care needs. It is vital that the matching process is thorough and that young people are not being overstretched;

b) the success of the Assisted Boarding Scheme will be an increased stability for some young people in care, which could be measured by a decrease in the number who move repeatedly from one foster

placement to another. The Scheme needs to be seen as a vital part of the Family Group Conferencing process;

c) the target age group of the Scheme is 10 to 12, which equates to school years 6 to 8. There is a smaller cohort of looked after children in these years, so the target group is limited. Evidence from similar schemes shows that there is much benefit to be gained, but to optimise the use of it, the decision making processes need to be developed;

d) the aim of the scheme is to give stability and pastoral care to those young people whose family lives are chaotic and who are of average or above average academic ability. It is not a 'special education' scheme for those with statemented special education needs;

e) although the results show good performance, the academic attainment of looked after children is, sadly, unlikely to match the performance of those not in care, as looked after children have the burden of having to contend with more emotional and behavioural problems than those not growing up in care; and

f) much support in the Virtual School Kent team is directed towards supporting young people in care to improve their academic performance, but one area of work currently identified as needing more attention is transition. Whereas other young people go through transition at predictable points in their academic careers (for example, when moving on from primary to secondary to upper school), young people in care can experience a broader range of transitions in a less predictable way.

3. RESOLVED that:-

a) the information set out in the report and given in response to comments and questions be noted, with thanks; and

b) all Panel Members be sent a copy of the thematic written report of the recent inspection of Virtual School Kent.

15. Staying Together Scheme
(Item B2)

Ms M Lowe, Performance and Quality Assurance Officer, Children in Care, was in attendance for this item.

1. Ms Lowe introduced the report and highlighted that very few of the carers who initially enquired about the scheme had chosen to proceed with it. This may be because they were disappointed by the financial arrangements available. Plenty of fresh enquiries have been received recently, however, and Independent Reviewing Officers advocate the scheme to carers for whom they feel it would be suitable.

2. A Panel Member with much experience as a Foster Carer told the Panel that she had looked into Staying Together and explained why she had chosen not to take it up. She had consulted a solicitor who advised her that the main financial benefit

would be for the KCC and not the child in care, as the latter would lose the entitlement to reduced university fees, for which they would have qualified as a looked after child. This loss of entitlement would mean, effectively, that the young man concerned would not have been able to afford to take up a University place. Due to this negative financial impact, the speaker was clear that she had made the right decision for him and would not take up Staying Together or Special Guardianship in the future for any other child in her care.

3. Ms Lowe said how saddened she was to hear this account and said the scheme was apparently not being properly described to carers. The protocols have recently been changed to state that young people will be considered on a case-by-case basis for support from secondary school onwards. Ms MacNeil added that the confusion and misunderstanding around the rules of the scheme is regrettable and needs to be clarified. She emphasised that the key aim of the scheme is to provide stability for young people; the financial arrangement is not its main focus. It was suggested and agreed that a report to a future meeting of this Panel set out and clarify the purpose and rules of the Staying Together scheme and Special Guardianship, and Ms MacNeil undertook to clarify the message to social workers to ensure that the right people get the right support at the right time.

4. Ms MacNeil responded to a question and explained that funding of the scheme is provided via the 'Access To Resources' Panel, to ensure parity of access, but Members expressed concern about the limitations and sustainability of this funding.

5. RESOLVED that:-

a) the information set out in the report and given in response to comments and questions be noted, with thanks; and

b) a report be prepared for a future meeting of this Panel to set out and clarify the purpose and rules of the Staying Together scheme.

16. Specialist Children's Services - Presentation
(Item B3)

Ms Y Shah, Coram/KCC Project Manager, was in attendance for this item.

1. Ms MacNeil presented a series of slides which updated Members on progress on the restructure of Specialist Children's Services, the Early Intervention and Prevention Strategy and progress on the review of the Adoption service. The adoption figures had been updated since the meeting papers had been prepared and new figures were tabled *and subsequently published on the website in place of the original paper*.

2. Ms MacNeil and Ms Shah responded to comments and questions from Members and the following points were highlighted:-

a) the recruitment of team managers is a challenge in a number of areas of the county, with both the quantity and quality of applicants being an issue. Although the national shortage of qualified social workers has been well documented, the shortage of good team managers is of

similar concern. Figures for specific areas of the county will be supplied to Members upon request;

b) the aim is that, to allow them to manage effectively, each team manager will lead no more than five or six social workers, each of whom should have a workload of no more than about fifteen cases at any one time;

c) Members found the structure charts very helpful and asked that all names and contact details be included on them, once these are known, and circulated to Members;

d) Ms Shah undertook to advise Members of the number of private inter-country adoptions and step-parent adoptions;

e) unaccompanied asylum seeking children (UASC) are usually older teens and hence not as suitable as younger children for adoption. However, having 'looked after' status, they would qualify for the same benefits upon leaving care as any other care leaver;

f) a recent review of the role of Adoption Panels has made changes to their function to lessen bureaucracy and help move young people in care towards permanent placements as quickly as possible;

g) in the common assessment framework, all agencies are expected to be able to identify, and hence share the responsibility to highlight, issues that they see in their work with a family. As families select whom they feel able to talk to about a problem, any agency working with them could be first to be told and then need to share information with professional partners; and

h) there is a difference in process for Foster Carers who later choose to adopt a child and those who go through the Concurrency procedure, and every family's circumstances are different. Both processes have challenges. The role of those moving from fostering to adoption will change, and good matching is vital to minimise disruption. A few Foster Carers can feel pressured to keep a child longer than they had intended to, and moving towards adoption may require them to re-think their life plan. Those who always intend to adopt, and use the Concurrency process to foster first, face different challenges. A child will be placed with them to foster but there is always the chance that court proceedings will mean the child has to be returned to its birth parents.

RESOLVED that:-

a) the information set out in the report and given in response to comments and questions be noted, with thanks; and

b) a report on the review of the Adoption Panels be submitted to the December meeting of this Panel.

Chairman …… 14 December 2012

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Decision 12/01981

By:	Graham Gibbens, Cabinet Member for Adult Social Care and Public Health Andrew Ireland, Corporate Director, Families and Social Care
To:	Social Care and Public Health Cabinet Committee 11 January 2013
Subject:	**KENT COUNTY COUNCIL'S ANNUAL REPORT (LOCAL ACCOUNT) ON ADULT SOCIAL CARE FOR APRIL 2011 TO MARCH 2012**
Classification:	Unrestricted

Summary: With the withdrawal of the Care Quality Commission (CQC) from assessing and rating Councils with Adult Social Care responsibility, there is now greater emphasis on Councils to work collaboratively to improve performance and outcomes for people. Sector Led Improvement is the national programme designed to do this, and one of the underpinning principles of the sector-led improvement programme in adult social care is a stronger accountability by using increased transparency to promote improvement in services. The publication of an annual Local Account is one means of achieving this.

Following Cabinet Committee in November, the KCC Annual Report (Local Account) has been further refined, incorporating comments from a variety of sources, including Cabinet Committee members.

The KCC Annual Report (Local Account) on Adult Social Care for 2012 is the start of an evolving process and the development of the 2013 account will begin much earlier, in January 2013.

Recommendations: The Cabinet Member for Adult Social Care & Public Health will be asked to take a decision to approve the KCC Annual Report (Local Account) on Adult Social Care for April 2011 and March 2012.

Members of the Cabinet Committee are asked to:

- Note the contents of this report and the Local Account
- Consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member
- Note the revised timescale for the 2013 process.

Introduction

1. (1) The Government's approach to the assessment of adult social care performance has changed in recent years. With the withdrawal of the Care Quality Commission (CQC) as the independent assessor of Council performance, there is now more emphasise on requirement for councils to manage their own performance, work collaboratively with the sector to improve performance and outcomes and explain how they have performed to local residents. The Local Account has emerged as standard feature of the new local accountability framework.

Policy Context

2. (1) The Publication of the 'Transparency in outcomes for Social Care' and the 'Vision for Social Care; Capable Communities and Active Citizens' in 2010, set out a future for people receiving support from Social Care which focused on outcomes, transparency and Quality and outlined the seven principles for a modern system of Social Care; Prevention, Personalisation, Partnership, Plurality, Protection, Productivity and people**.**

(2) The publication of the "Think Local, Act Personal" in 2011, a partnership agreement developed and co-designed by a number of national and local social care organisations, including service users and carers, set out the shared ambitions for moving forward with personalisation and community based support.

(3) More recently, the publication of the White Paper, "Caring for our future; reforming care and support" reinforces these visions, placing emphasis on maintaining independence, choice and control, quality, dignity and respect and clear information advice and guidance.

(4) With accountability moving from being a relationship between Councils and CQC to being a relationship between Councils and their communities, there is an expectation that Councils will work with their local communities, transparently. In addition, a new national performance framework is evolving which will help councils to manage their own performance collectively, through 'Sector Led Improvement' as well as to help Government to monitor the progress with these key priorities. It is expected that Councils will publish a "**Local Account**" to enable their service users, carers and communities to be able to hold them to account.

(5) Kent County Council published its first ever KCC Annual Report (Local Account) on Adult Social Care in December 2011. The attached document **(Appendix 1)**, is the latest version of this report, which is under consideration is to be taken forward under the KCC's Key Decision procedures and after due process it will be agreed by the Cabinet Member for Adult Social Care and Public Health.

Development and content of the KCC Annual Report (Local Account) on Adult Social Care

3. (1) The first draft of the KCC Annual Report (Local Account) on Adult Social Care was presented to Cabinet Committee in November 2012 and was structured around the key themes in the White paper.

(2) Following Cabinet Committee, a briefing was held for Cabinet Committee members to look at the context and the development of the account in more depth.

(3) Amendments and corrections have been made to this account in light of that useful discussion.

KCC Annual Report (Local Account) for 2013

4 (1) Although the development of the 2011/2012 KCC Annual Report (Local Account) has been informed by public engagement exercise and it involved service users, carers, representatives of the LiNK, there is more to do for 2013.

(2) In 2013, the KCC Annual Report (Local Account) needs to engage more service users and carers, including partnership boards and the voluntary sector, as well include more timely information and data.

(3) It is proposed that this process starts much earlier on, in January 2013, so that Cabinet Committee can see the draft 2013 KCC Annual Report (Local Account) in June 2013.

Recommendations

5. (1) The Cabinet Member for Adult Social Care and Public Health will be asked to take a decision to approve the KCC Annual Report (Local Account) on Adult Social Care for April 2011 and March 2012.

(2) Members of the Cabinet Committee are asked to:

i) Note the contents of this report and the Local Account
ii) Consider and either endorse or make recommendations on the proposed decision to be taken by the Cabinet Member
iii) Note the revised timescale for the 2013 process

Appendix

Appendix 1: Kent County Council's Annual Report (Local Account) on Adult Social Care for April 2011 to March 2012.

Background Documents

Transparency in outcomes for Social Care' 2010

Vision for Social Care; Capable Communities and Active Citizens' 2010

Think Local, Act Personal 2011

Caring for our future: reforming care and support White Paper, Department of Health, 11 July 2012.

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Kent County Council's Annual Report (Local Account) on

Adult Social Care

Kent County Council's Annual Report (Local Account) on Adult Social Care April 2011 to March 2012

Kent County Council kent.gov.uk

Contents

Foreword

Graham Gibbens

Andrew Ireland

By: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health and Andrew Ireland, Corporate Director for Families and Social Care

We are pleased to publish Kent County Council's Annual Report (Local Account) on Adult Social Care, for the period April 2011 to March 2012.

The Annual Report is a document for reporting back to Kent residents about the performance of Adult Social Care. It is an important part of the Kent County Council's commitment to be transparent with local residents about what we do and how we spend money allocated to Adult Social Care.

The Annual Report provides one of the means for setting out the main achievements, areas for further development as well as the key challenges that were encountered during the last year. Many of the accomplishments could not have been achieved without working in partnership with people who receive services and carers as well as other statutory and non-statutory organisations.

We are pleased to point out that the development of this Annual Report was informed by service users, carers, partner organisations and the views of Kent County Council's Social Care and Public Health Cabinet Committee.

Keeping vulnerable adults safe remained one of our key priorities during the year. As ever, we have worked hard with all the key partners to raise awareness of safeguarding issues. However, there are particular steps we can take to improve our preventative approach to safeguarding and this will be a focus for next year.

We know that for people who receive services and their carers, the quality of the care they receive is important to them. This is an issue that has also been top of our agenda. As a result, Adult Social Care ensured that both the services managed by the council and those commissioned from the private and voluntary sectors were monitored for the quality of services provided.

In 2012/13, we will progress our work on the Adult Social Care Transformation Programme and work closely with our NHS partners to provide more joined up and integrated health and social care. We also want to ensure those who need to enter the social care support system have the information and tools to manage their own care needs. The Transformation Programme will help to stimulate a range of service providers and support in the social care market. It will also encourage providers who are able to deliver personalised care and support that can increase people's ability to recover from illness and enables them to remain independent.

Introduction

As part of our usual way of producing reports, we involved a group of Kent residents in developing this report. This included service users, carers and representatives of organisations such as Kent Links (shown in the photograph images below). We would like to thank all the people involved for their contribution and hope they and others will continue to work with us in next years report.

The purpose of this Annual Report

In the past the Care Quality Commission used to inspect how well Local Authorities with responsibility for Adult Social Care were doing. As part of national changes all local authorities now have to directly report back to their residents on their performance and delivery of Adult Social Care. As a result we will publish an Annual Report (Local Account) that describes what we have done and our priorities for the coming year.

This report is called **Kent County Council's Annual Report for 2011/12.**

What you will find in this Annual Report

In June 2012 the Department of Health published a document that set out a vision for the future of Adult Social Care. This document is called '**Caring for our future: reforming care and support'** White Paper in which there are 5 key themes (set out below). In this Annual Report we have given you a summary of the council's performance and delivery of Adult Social Care against each of these themes. We have included a sixth theme on carers because this is also important.

SECTION 1	**Theme 1**	I am supported to maintain my independence for as long as possible.
SECTION 2	**Theme 2**	I understand how my care and support works, and what my entitlement and responsibilities are.
SECTION 3	**Theme 3**	I am happy with the quality of my care and support.
SECTION 4	**Theme 4**	I know that the person giving me care will treat me with dignity and respect.
SECTION 5	**Theme 5**	I am in control of my care and support.
SECTION 6	**Theme 6**	I am supported as a carer.

The current position in Kent

As the government seeks to reduce the national deficit, the level of funding to local public services has also been reduced. This has been during a time when demand for public services, particularly in children and adult social services continues to increase and when there are also significant demographic changes.

To meet these challenges we have had to rethink how we do things in the council as by 2013, Kent County Council is expecting to operate with a budget that is around £195 million less than it is now across the whole council. Some of this will impact on adult social services. The plan we will use to achieve this is set out in Kent County Council's **Bold Steps for Kent**[1] document which outlines the councils priorities for the next three years. It sets out how the council will transform how it works and engages with the communities it serves, as well as with our partners in the public, private and voluntary sector. More information on this document can be found at:- www.kent.gov.uk/your_council/priorities,_policies_and_plans/priorities_and_plans/bold_steps_for_kent.aspx

The Families and Social Care Directorate, which has responsibility for delivering Adult Social Care is considering the current financial pressures and how best to respond in these challenging times. How we plan to achieve this is due to be set out in a document called **The Adult Social Care Transformation Programme**[2] .

1 **Bold Steps for Kent The Medium** Term Plan to 2014/15. This sets outs Kent County Council's medium-term plan for the next four years, which was approved by the County Council on 16 December 2010.

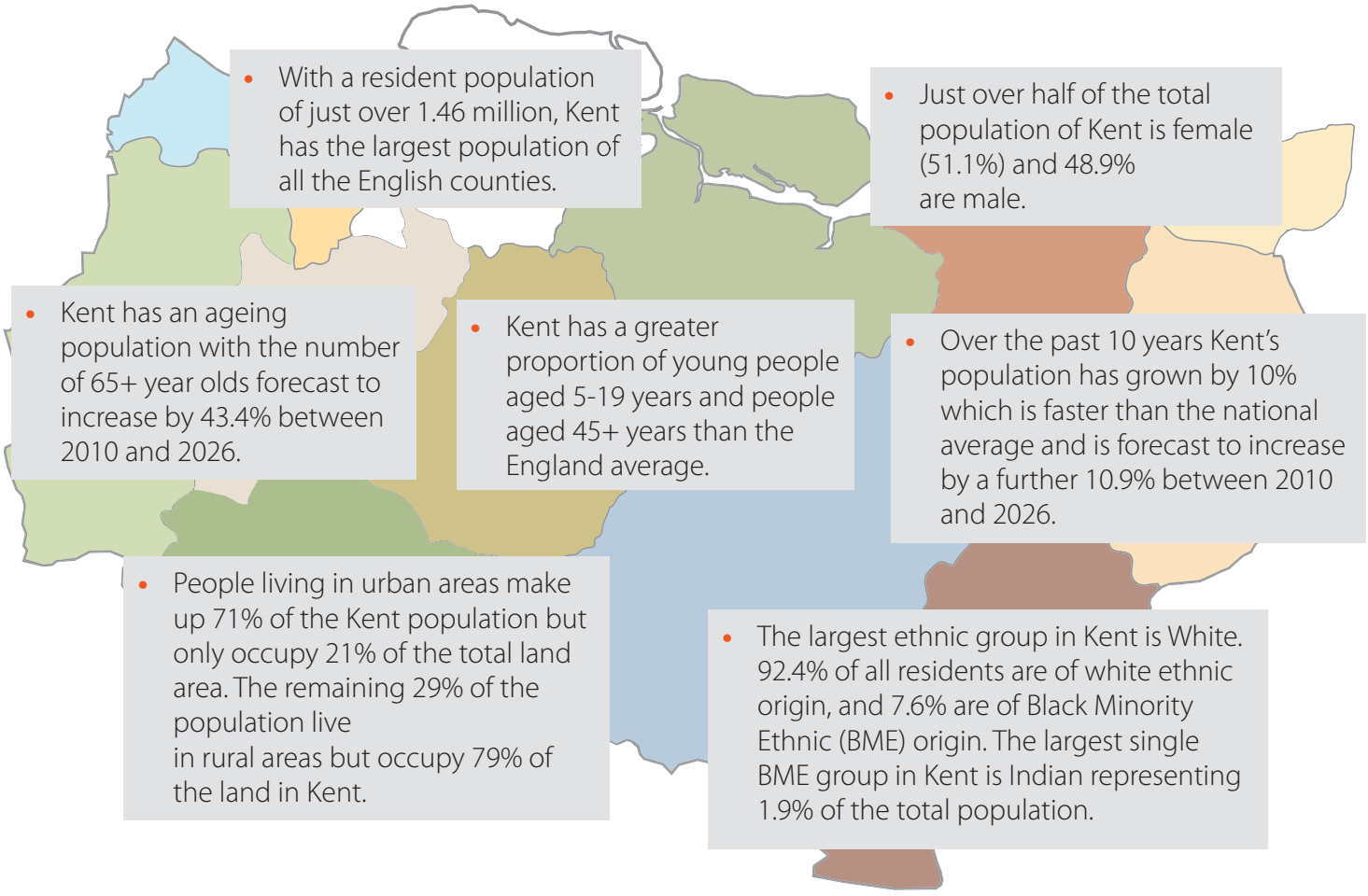
2 **The Adult Social Care Transformation Programme** was endorsed by the Council in May 2012 in a document called **The Transformation Blueprint and Preparation Plan,** this will be a starting point in the future shaping of Adult Social Care in Kent.

Kent and its people

Kent County Council believes and recognises the diversity of Kent's community and workforce is one of its greatest strengths and assets. The different ideas and perspectives that come from diversity will help the council to deliver better services as well as making Kent a great county in which to live and work. Further information on the council's objectives for equality and diversity can be found at www.kent.gov.uk/yourcouncilpriorities policies and plans/policies/equalityanddiversity.aspx

During the last year the council developed new equality objectives to help better understand how and where we can make a difference as part of the work that we do.

Some facts and figures about Kent...



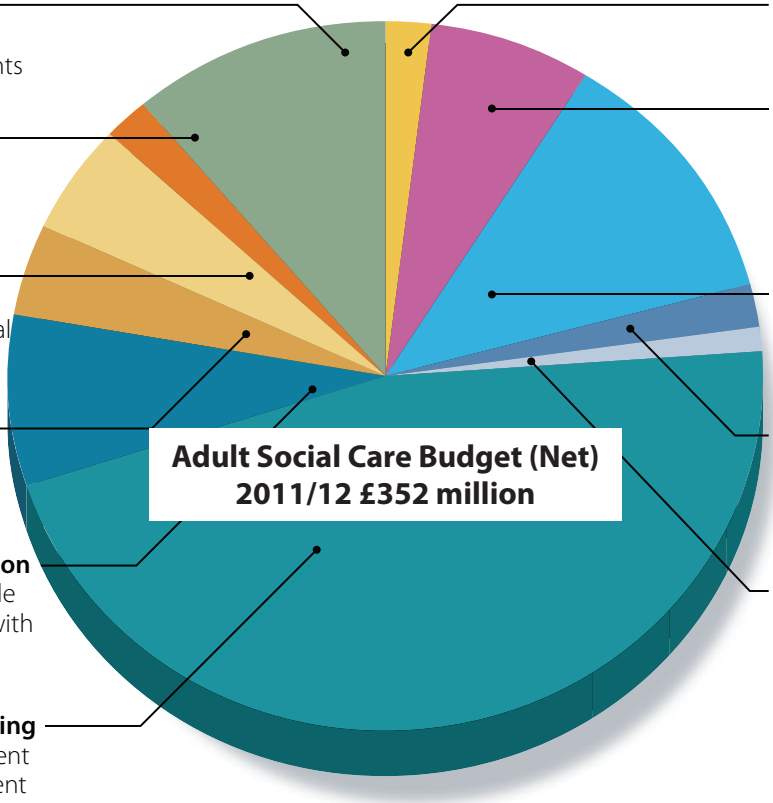
- With a resident population of just over 1.46 million, Kent has the largest population of all the English counties.
- Just over half of the total population of Kent is female (51.1%) and 48.9% are male.
- Kent has an ageing population with the number of 65+ year olds forecast to increase by 43.4% between 2010 and 2026.
- Kent has a greater proportion of young people aged 5-19 years and people aged 45+ years than the England average.
- Over the past 10 years Kent's population has grown by 10% which is faster than the national average and is forecast to increase by a further 10.9% between 2010 and 2026.
- People living in urban areas make up 71% of the Kent population but only occupy 21% of the total land area. The remaining 29% of the population live in rural areas but occupy 79% of the land in Kent.
- The largest ethnic group in Kent is White. 92.4% of all residents are of white ethnic origin, and 7.6% are of Black Minority Ethnic (BME) origin. The largest single BME group in Kent is Indian representing 1.9% of the total population.

Source: Kent County Council, Business Intelligence, Research and Evaluation

Adult Social Care in Kent

What do Adult Social Services do?
Adult Social Services has a statutory responsibility for the assessment, planning and arranging of provision of community care services for adults living in the Kent County Council area who may qualify for social care support. Adult social services generally support older people, people with physical disabilities, people with sensory disabilities including dual sensory impairment, people with learning disabilities, people with mental health problems, people who are being supported by children's social services who turn 18 years and may require support from adult social services and people who give (unpaid) care to family members or friends.

How we spent money on Adult Social Care in 2011/12
In 2011/12 the council spent £352 million on Adult Social Care, which accounts for 33% of their total net spend on public services for 2011/12. The chart below shows how this money was spent. Further information on the council's financial accounts can be found at:
www.kent.gov.uk/your_council/council_spending/financial_publications/statement_of_accounts.aspx



Assessment
Staff costs for carrying out community care assessments
£39,259k

Occupational therapy equipment and client transport
£6,100k

Day care
support accessed during the day, often to meet social isolation needs
£18,336k

Voluntary organisations
contributions toward preventative services
£14,624k

Supported Accommodation
housing that enables people to live independently but with support
£28,687k

Residential care and nursing care includes non-permanent (respite) as well as permanent
£161,764k

Management, commissioning and operational support costs
£8631k

Direct payments
money which is passed directly to clients so they can purchase and manage services that meet their assessed eligible needs
£23,836k

Domicillary care
care services provided to people in their own homes
£41,979k

Enablement
intensive short term support which encourages people to be as independant as possible
£6,6567k

Extra care housing accommodation with varying on site support
£1,927k

Which groups of people the money was spent on in 2011/12

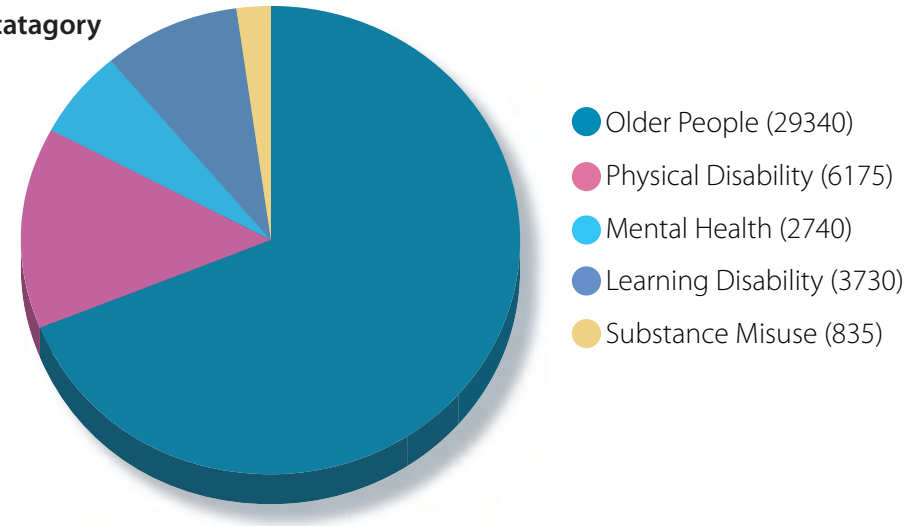
	£		
Client group	**Gross**	**Income**	**Net**
Older people	197,148	-67,644	129,504
People with Physical Disabilities	30,958	-2,673	28,285
People with Learning Disabilities	136,487	-8,619	127,868
People with Mental Health needs	14,217	-2,065	12,152
Other adult services	23,248	-8,518	14,731
Assessments and Related Services	41,282	-2,023	39,259
TOTAL ADULT SOCIAL CARE	443,340	-91,542	**351,799**

These figures are 2011-12 budget excluding grant income that also applies to the pie chart on page 7.

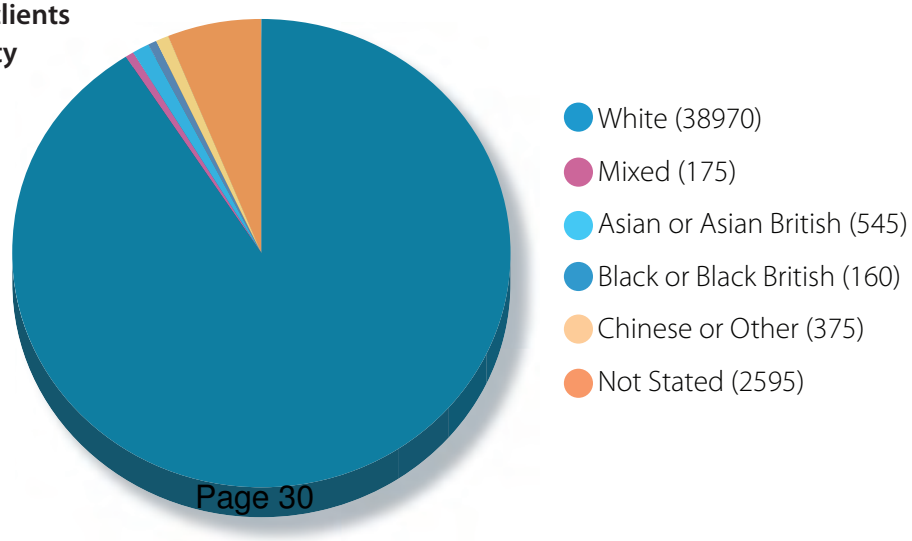
How many people the council supported in 2011/12

The council supported 40,000 people in 2011/12 as shown in the chart below:

Piechart to show the proportion of clients we supported in 2011/12 by client catagory



Piechart to show the proportion of clients we supported in 2011/12 by ethnicity



SECTION ONE

Theme 1: I am supported to maintain my independence for as long as possible

People want to stay in their homes for as long as is possible and so we have developed a range of services to support and enable people to live independently in their homes or in supported living.

Some of the ways in which we do this are:-

- **Assistive Technology** services provide support in the person's home using technology such as Telecare and Telehealth. For example fall detectors can be fitted in the home and linked to a call response centre.
- **Enablement services** provide short term, intensive and targeted support to help people regain, maintain or develop the skills and confidence to carry out daily living tasks to the best of their ability (for example after an illness, fall or operation), so they can continue to live independently in their home.
- Our **Community Equipment** Service provides a range of equipment e.g. grab rails and small adaptations in people's homes so they can continue to live safely and independently at home. Communication aids and specialist equipment are also provided for people with sensory impairments.
- A **range of community support services** are provided by the Community and Voluntary Sector and the Private Independent Sector.

How did we do?

During 2011/12:-

- 1,032 people received Assistive Technology services.
- 6,800 people received Enablement services of which 69% of people were able to return to their home without any further support from social services.
- 13,485 people were provided with equipment or adaptations in their home, with over 30,000 items of equipment and 10,000 minor adaptations being provided.
- 2,270 people were provided with 6,095 pieces of specific sensory equipment.
- 1,723 people received a meals service in their home.
- 16,084 people received a home care support service to enable them to stay in their home.
- 3,213 people received a day care service.
- We provided £15 million funding through grant agreements and contract arrangements with the voluntary and community sector to provide a range of community support services. These included bathing, befriending, support groups, home care, day care, short breaks, information and advice services and specialist support for people with dementia and their carers.
- Kent Supported Employment (who offer specialist employment support to people with a learning disability, mental health issues, physical disabilities and long term health issues), worked with a range of specialist and local employment services across Kent to support 636 people into paid employment, education and training.
- "Advocacy for all" is a county wide advocacy service for people with a learning disability, supporting them to make decisions and choices.

SECTION ONE

Theme 1: I am supported to maintain my independence for as long as possible

'Areas for development'

Understand why some people are not feeling clean and presentable through their reviews and surveys

What did you tell us?

- 55.6% of people said that they felt clean and presentable.
- 84.4% of people said that care & support services helped them in keeping clean and presentable.
- 69.1% of people said that care and support services helped them to get food and drink.

Source: The 2012 National Service User Survey - Kent Position

What we are planning to do next year as part of the Adult Social Care Transformation Programme:-

- Continue to develop and increase availability of community support services and assistive technology services across Kent.
- Place a greater focus on enablement services and rapid response services for people in crisis, so we are doing everything we can to increase a person's ability to recover from illness and remain independent for as long as is possible.
- Launch the Supporting Independence Service to enable people with mental health and learning disabilities to reach their full potential and live independently in the community.
- Continue to work in partnership with housing providers on the development and availability of appropriate housing options for people with learning disabilities.

"Telecare was installed recently to support my frail uncle. As his carer I was increasingly concerned about the number of calls especially at night. However Telecare equipment has allowed me (and him) to be reassured that in the event of a fall he can call for help immediately. Without telecare he would have laid on the floor all night".

(Comments from a carer)

SECTION ONE

Theme 1: I am supported to maintain my independence for as long as possible

Case Study

Mr Sam has Alzheimer's Disease and lives with his wife who has been his sole carer for the past 5 years. Mr Sam often wanders so Mrs Sam had taken to keeping the doors locked at all times and sleeping with the keys under her pillow at night. There was installation of telecare equipment which included property exit sensors linked to a carer's pager to alert Mrs Sam should her husband attempt to wander from the property. Installing this in the home allowed Mrs Sam to sleep better at night knowing she would be alerted if her husband tried to leave the property, without restricting his movements within the home.

Case Study

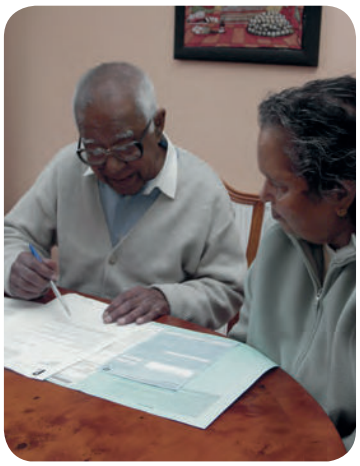
"Talk Time" sessions were held in many Kent libraries. These informal drop-in sessions helped to bring older people together to reduce their social isolation. In 2011/12 a total of 3,436 sessions were held, which offered a variety of activities ranging from using archive services, speakers and quizzes to recreational activities or just tea and chat.

"I think Talk Time is an excellent idea to meet and have a chat and then select books in the library. The staff at the Library were very helpful.

(Comments received from a person who took part in the Talk Times sessions).

SECTION TWO

Theme 2: I understand how my care and support works and what my entitlements and responsibilities are



People want to be able to access quality information, advice and guidance when they need to. We need to ensure people who contact us have a positive experience which provides them with the right amount of information at the time they need it. This can help people understand how their care and support works and also what service(s) they are entitled to. In this way people can make informed decision(s) about their care and support and in doing so are able to help themselves and others in their community.

Some of the ways in which we do this are:-

- Our **Gateways** support Adult Social Care services by offering a local venue and facility so people can access a range of care and support services quickly and easily.
- The **Kent Contact and Assessment Service** is a dedicated team based in the Contact Centre, providing people with the opportunity to discuss concerns and possible care needs either about themselves or for other adults in need.
- Information on local care and support services for adults is also provided across Kent by our **Libraries services**.

Case Study

The Nepalese Elder Meeting Point was a huge success last year, this is a regular drop-in facility held at Cheriton Library that provides information on health and well being for the older members of the Nepalese community. In 2011/12 137 sessions were held.

How did we do?

During 2011/12:-

- We developed a shared assessment process so people could have a more joined up and quality service from Health and Adult Social Care.
- We began the development of integrated health and social care community based teams so that health and social care staff could be located in one office.
  This new service is being trialled in the Dover area for 1 year to find out how it works.
- We provided an assessment service to 27,589 people. We also provided training and awareness for staff that carry out an assessment, so the right assessment is provided for the person at the right time.
- Our specialist Welfare Benefit Advisors provided support and representation to 850 of our clients, who had complex benefit issues or were involved in a benefit claim dispute with one or more Benefit Agencies. Some examples of this included supporting clients whose disability benefits were under review following a change in their circumstances, and challenging incorrect benefit decisions on behalf of clients through the appeal tribunal system.
- The Gateways saw 679,749 people pass through its doors. The Gateways supported Adult Social Care by offering a local venue to hold Blue Badge assessments and Bathing Assessment and deaf services clinics. Gateways also offered access to clinics with voluntary organisations including Age Concern, Scope, Royal British Legion, Hi Kent and Kent Association for the Blind.
- The Kent County Council Customer Service Strategy was produced which sets out our vision of how we want to achieve high quality customer service and also make it easier for our customers to reach us when they need us.

SECTION TWO

Theme 2: I understand how my care and support works and what my entitlements and responsibilities are

How did we do?

- Over 128,770* people contacted the council for advice and information regarding Social Services. Of these, 36,172 people were referred to Kent Contact and Assessment for further assessment and for more detailed advice. *(figure includes Children's Social Services)
- 13,000 people used the Kent Care Services Online Directory which is an online database of all known Care Services in Kent. The public can use this to search for the service they require by service type and area.

'Areas for development'

Improve access to information, advice and guidance so people are clear where they need to go locally.

What did you tell us?

- In the past year 52.6% of people have found it either very or fairly easy to find information and advice about support.

  Source: The 2012 National Service User Survey - Kent Position

What we are planning to do next year as part of the Adult Social Care Transformation Programme:-

- Improve access and availability of information, advice and guidance services in Kent so people get the right information, advice and guidance and in an accessible format when they need it. In this way people can make the best choices about their care and support.
- Make it easier and quicker for people to request an assessment for health and social care needs by setting up local integrated health and social care access points across Kent. This includes looking at ways in which people can complete their own social care needs assessment.
- To continue to increase awareness of Dementia through our Gateways and Libraries services.
- Work with social workers in children's social services to help ensure young people (and their parents or carers) have a smooth transition from specialist children services to adult social services.
- Increase access for people with learning disabilities to screening and health promotion programmes including annual health checks.

"I feel relieved the Gateway service is here. It makes access easy for deaf people".
(Feedback from John).

Case Study

John has a hearing disability and lives alone and feels socially isolated. He has poor literacy skills, so is afraid to throw away anything delivered through his letter box which resulted in his flat being filled with sacks of correspondence and junk mail. With the support of our deaf services team, John managed his correspondence regularly via the gateway drop-in visits, joined a local deaf walking group and became an enthusiastic member of the deaf theatre group.

SECTION THREE

Theme 3: I am happy with the quality of my care and support

People think the quality of care and support that is provided to them is an important aspect of the service they receive.

Some of the ways in which we do this are:-

- **By working with the providers[1] that we contract** with, to ensure they maintain quality standards of service and (where needed) improve standards of care they provide.
- **By using customer feedback** including the complaints and compliments we receive from people who use our services. We think this is a good way of finding out about the quality of services.
- **Encouraging people to tell us what they think about the quality of their care and support,** when we carry out a review of the service(s) they receive.

How did we do?

During 2011/12:-

- We introduced a new system to help us work more effectively and swiftly with care providers where there were issues about the quality of service they provided. This system is called the Quality Care Framework and has enabled us to work with providers in a positive way.
- 6140 people were provided with long term care and support in a residential or nursing care home.
- We worked closely with the Care Quality Commission (a government inspectorate which inspects the quality of social care and health services in England) by having regular meetings with them to share information where serious quality issues and/or poor practices were reported.

How did we do?

- We received 425 statutory complaints[2] and 295 enquiries[3]
- We received 575 compliments in 2011/12.
- A total of 30,441 people received a review of their service.

1 Providers are the organisations that we contract with to provide care and support that people need such as care homes, extra care housing schemes and domiciliary care agencies who provide care for people in their own homes. Each provider works to a contract specification which outlines the services we expect them to provide.

2 A statutory complaint is an expression of dissatisfaction or concern that requires a response.

3 An enquiry is when someone makes an enquiry about a service on behalf of someone else.

SECTION THREE

Theme 3: I am happy with the quality of my care and support

'Areas for development'

Ensure that people's needs and outcomes are reviewed and staff are fully trained to ask about the things that concern and worry people, including concerns about the quality of the services they receive.

What did you tell us?

- 57.7% of people were either extremely or very satisfied with the care and support services they received.
- 61.9% of people felt as safe as they wanted.
- 75% of people felt that care and support services helped them to feel safe.

Source: The 2012 National Service User Survey - Kent Position

What we are planning to do next year as part of the Adult Social Care Transformation Programme.

- Make it easier and clearer for the public on who to contact in the council if they have a complaint.
- Set up a "Quality Team" to closely monitor and promote quality of services so that any concerns about poor quality of care are addressed before anyone is harmed.
- Continue to work in partnership with Health to improve the skills and capability of targeted care homes.

Case Study

A care home in the Kent area was deemed as failing by the Care Quality Commission who subsequently issued a compliance notice against the care home. However following close working by our contracting staff with the home manager, the home was able to demonstrate improvements in the quality of care they provided. As a result no further action was taken by the Care Quality Commission.

SECTION FOUR

Theme 4: I know the person giving me care will treat me with dignity and respect

People should be treated with dignity and respect at all times, which is about taking time to understand what is important and matters to them.

Some of the ways in which we do this are:-

- Through a range of **training programmes** available for staff working in adult social care. We believe having appropriately trained staff is key to ensuring people are treated with dignity and respect.
- We respond sensitively to any concerns that are reported to us about an adult who is particularly vulnerable and has been or may be at risk of harm and abuse. **The Kent and Medway Safeguarding Vulnerable Adults Board** is a multi-agency partnership between Health, Police and Kent and Medway which ensure that safeguarding processes are in place and working properly when concerns about abuse are reported.

How did we do?

During 2011/12:-

- We launched the "My Home Life Initiative" which provided training and opportunities for shared learning for providers of care homes in Kent.
- We worked with care home providers to set up "Dignity in Care Champions" in their homes. Their role was to share good practice amongst staff in the home and to ensure residents were always treated with dignity and respect.
- A total of 318 training courses that covered dignity and respect were delivered to both staff and care professionals working in the Private, Independent and Voluntary sector. These included training on assessment, support planning, dementia awareness, HIV and Aids, moving and handling of people, stroke awareness, end of life care, mental capacity, and specific disability conditions.
- We received 2,341 safeguarding referrals of which 46% of cases had abuse confirmed or partially confirmed, 35% of cases were not evaluated as abuse or were discounted, and 19% were inconclusive. Each case is very individual and people are supported through the process carefully. In those cases that are deemed inconclusive, there may be many factors which make it difficult to draw definite conclusions. However practice audits of safeguarding cases suggest that investigations are reaching the right outcomes with people being safeguarded and Kent's performance is in line with the neighbouring local authorities such as Essex and West Sussex.
- We worked in partnership with the NHS, Police and District Councils to raise awareness of safeguarding issues amongst the public through events such as the Annual Safeguarding Awareness week and our website.
- We undertook a programme of regular audits of adult protection cases to monitor the quality of practice.
- We developed a more streamlined investigation process for all safeguarding concerns so cases could be dealt with in a timely way.
- We introduced a Competency Framework for staff working in safeguarding. This is a tool used in staff supervision to evaluate and improve the practice of individual workers in respect to safeguarding work.
- We developed a Central Referral Unit in conjunction with our partners. This is a multi-agency unit of Social Services (children and adults), Police and Health to help deal with new safeguarding referrals.

SECTION FOUR

Theme 4: I know the person giving me care will treat me with dignity and respect

How did we do?

- We continued to deliver a programme of training on safeguarding procedures for staff and partners as well as people working in the Private Independent sector.
- The Kent and Medway Independent Mental Capacity Advocacy service (which all councils have a statutory duty to commission) provided 5,900 hours of advocacy to unbefriended, vulnerable adults, who were deemed to lack capacity to make certain important decisions including serious medical treatment and major change of accommodation.

'Areas for development'

- Ensure that personal outcomes are discussed and reviewed more sensitively.
- Gather feedback from people after their safeguarding investigation has been completed.

What did you tell us?

- 53.0% of people stated that having help to do things made them think and feel better about themselves.
- 52.8% of people stated that the way they are helped and treated made them think and feel better about themselves.

Source: The 2012 National Service User Survey.

What we are planning to do next year as part of the Adult Social Care Transformation Programme.

- Continue development and training of staff that carry out safeguarding investigations and continue to audit and monitor quality of practice.
- Look at new ways of raising awareness about adult abuse and domestic abuse as well as continue to support the Safeguarding Awareness Week in Kent to ensure that people know how to contact us.
- Look at ways in which we can obtain feedback in a sensitive way from people who have been the subject of a safeguarding investigation and use their experiences to improve practice.

Case Study

The daughter of Mr Foster contacted Adult Social Care Services to report that her father was reluctant to leave his room as recently he had noticed money going missing from the security tin in the draw in his room. A safeguarding alert was raised. With Mr Foster's agreement the police installed a hidden camera in his room to find out who may be responsible.

A few days later the camera recording was checked and it showed a member of the cleaning staff removing money from the tin. The police arrested the worker in possession of the marked notes who was charged with theft and pleaded guilty in court.

SECTION FIVE

Theme 5: I am in control of my care and support

People should have choice and control over the care and support they receive. This can enable people to receive more personalised services that meet their individual care and support needs in a way that works best for them.

Some of the ways in which we do this are:-

- People can have personalised care and support **through a Personal Budget** which tells them the amount of funding available for meeting their eligible care and support needs. These needs would have been identified during the person's community care assessment.
- A person can receive their Personal Budget either **through a Direct Payment** which is paid directly to them so they can buy and arrange their own care and support. **The Kent Card** is one way in which a person can receive a Direct Payment.
- Another option for the Personal Budget is for the Case Manager to arrange the care and support on behalf of the person.
- We are also testing out another way for people to receive Personal Budgets which is called **Provider Managed Services**. This is an option for people who want their care provider to plan and arrange the care and support they need by using the personal budget that has been paid to them.
- **Support Plans** also give people choice and control as they enable a person to arrange and set up their care and support in a personalised way.

How did we do?

During 2011/12:-

- Approximately 14,895 people received a Personal Budget.
- 2,272 people decided to take their Personal Budget as a Direct Payment.
- 514 people chose to receive their Direct Payment through a Kent Card.
- 74% of clients had a support plan set up to enable them to arrange their care and support in a personalised way.
- Our Personalisation Coordinators provided support, recruitment and employment advice to people who chose to use their Direct Payment to employ their own carer(s), known as personal assistant.
- The Good Day Programme[1] (which is in its fourth year) developed over 60 different projects that offered people with learning disabilities more choice and access to a range of person centred day services within their local community.

'Areas for development'

- All eligible people will have a personalized support plan and a personal budget.
- Develop alternative ways for people to spend their personal budget.

1 The Good Day programme was launched 4 years ago as a response to the many people with a learning disability living in Kent who wanted to see a change in the way they accessed day services.

SECTION FIVE

Theme 5: I am in control of my care and support

'Areas for development'

- Ensure that personal outcomes are at the centre of assessment and planning
- Ensure that service users know how to contact us.

How did we do?

- The Partnership Strategy for Learning Disability in Kent was produced so Kent County Council and its partners can work together to ensure people with learning disabilities who live in Kent have real choice over the areas of their lives that are important to them. The strategy will ensure people with learning disabilities have the same rights and entitlements to the same opportunities and services in their communities as everyone else.
- The Learning Disability Partnership Board works with all partners to make sure this strategy is planned, acted on and achieved. The strategy involved a great deal of work with partners, people with learning disabilities and family carers.

What did you tell us?

- 32.3% of people reported they had as much control over their daily life as they wanted, with a further 44.4% having adequate control over their daily life.
- 87.7% of people stated that care and support services helped them to have control over their daily life.
- 24.4% of people said their quality of life was so good it could not be better.
- 91.8% of people thought that care and support services helped them to have a better quality of life.

Source: The 2012 National Service User Survey - Kent Position

What we are planning to do next year as part of the Adult Social Care Transformation Programme.

- Increase the uptake and use of the Kent Card.
- Ensure all service users who have eligible on-going needs are allocated a Personal Budget.
- Work with the Primary Care Trust to develop Personal Health Care Budgets so people receiving Health services can also arrange services to meet their health care needs.
- Continue the work of the Good Day Programme to transform the way leisure, day and work activities are provided, so people with learning disabilities can have greater choice and access to more person centred services in their local community.

Case Study

Susan has learning and physical disabilities and is a tenant in private rented accommodation. She had been feeling unhappy with her care arrangements, since the care workers were not always able to work during the hours she wanted them to. She also did not always know the person who was coming to support her. With the support of an advocate Susan chose to receive her Personal Budget as a Direct Payment and employed her own personal assistant. Susan is now much happier as she receives her care and support in a personalised way.

SECTION SIX

Theme 6: I am supported as a carer

We value the role of carers and recognise that although carers may want to care for their family member or friend, they may need support and regular time away from caring to carry on doing so.

Some of the ways in which we do this are:-

- Much of the **support and services provided for carers** are delivered on our behalf through a range of partnerships, grants, service agreements and\or contracts with the Voluntary and Community sector and the Private Independent sector.
- A carer can also request a **Carers' Assessment,** which can help assess their needs and identify what support could help them in their caring role.
- **Short breaks** are services provided to the cared for person to enable the carer to have a break from their caring role. The cared for person must have an eligible level of need. The short break can be provided in a community setting such as a day centre, in the home or taking the cared for person out for the day, or in a residential care home where the cared for person is cared for away from their home.

How did we do?

During 2011/12:-

- A total of 20,234 Carers Assessments were completed for carers.
- Over 300 "something for me payments" were used by carers to purchase something they decided could help make life easier for them. Some of the things that carers bought using this payment were for example short day trips and gym memberships.
- Over 700 carers signed up to have a Kent Emergency Card which they carry at all times, so if they were taken ill or involved in an accident they have peace of mind that anyone who found the card could access emergency assistance for their loved one.
- Nearly 1,000 people with dementia and their carers were supported by the Dementia 24 hour helpline and Dementia crisis support service. In addition there were over 100,000 hits on the Dementia website and the six Dementia Cafes across Kent provided informal drop in sessions for carers looking after someone with dementia.
- Our Carers Advisory Group which includes representatives from all partner organisations across Kent, who are involved in supporting carers, continued to work jointly to develop local services that can meet current and future carer needs.
- The Carers Reference Group which is made up of carers from across Kent also supported the Carers Advisory Group to ensure the needs and wishes of carers were represented and discussed.
- We developed a Sensory Carers Project in partnership with Hi Kent and the Kent Association for the blind to improve access to and awareness of services for carers of people with sensory impairments.

SECTION SIX

Theme 6: I am supported as a carer

'Areas for development'

- Ensure all carers have access to an assessment
- Ensure carers know how to contact us.

What did you tell us?

- 55.1% of people were extremely or very satisfied with the support or services they and the person they cared for received.
- 87.8% of carers stated that the support or services they received 'have made things easier for me.'
- 74% of carers felt they had the right amount of support for the cared for person.
- 60.2 % of people were extremely or very satisfied with support and services which enabled them to take a break for over 24 hours.
- 69.2% of people were extremely or very satisfied with support and services which enabled them to take a break between 1-24 hours.

Source: The 2009/10 Carers Survey

Case Study

Mrs Saunders has dementia and in February her husband who is her main carer, fell off a ladder and broke his collar bone. As a result Mr Saunders struggled to continue his caring duties for his wife. Mrs Saunders daughter contacted a local carer's organisation to find out if they could offer any support whilst her father was recovering. A short term home care support was arranged by the carer's organisation. The carer's organisation said "Mr and Mrs Saunder's daughter phoned us at a later date to say her father had recovered much quicker as our visits gave him the opportunity to rest".

"Mum and I really enjoy the Cafés, especially the variety of talks and entertainment that we have. Everyone joins in and is friendly. It is a huge benefit. Every talk has been helpful, for instance we got mum a GPS watch after one talk. Mixing with other people has helped us to see that we are not on our own".

(Comments from a carer)

"It was a life line to find the Dementia Café and to be able to talk to other carers and staff about day to day problems. I particularly look forward to the interesting guest speakers and have benefitted by their knowledge and learnt what is available to carers. I would like to thank all those who helped us to cope with our problems.

(Another carer wrote about her experience at the Dementia Café).

Your views and feedback

We would like to know what you think of this Annual Report as your views and feedback will help us in preparing next years report for 2012/13.

- Was this report easy to read and understand?
- Did it give you useful information about Adult Social Care and how it is deliverd in Kent?
- Were there any areas of the report that we could improve upon for next year**?**
- Is there anything else you would like to say about this report?

If you would like to give your views or feedback then please send them to us:-

By e-mail: KentLocalAccount@kent.go.uk

Write to us at: Local Account Feedback,
Performance and Information Management team,
Strategic Commissioning,
Families and Social Care,
Kent County Council,
3rd Floor Brenchley House,
Week Street,
Maidstone,
ME14 1XX.

By:	Jenny Whittle – Cabinet Member for Specialist Children's Service
	Andrew Ireland – Corporate Director for Families & Social Care
To:	Social Care & Public Health Cabinet Committee – 11 January 2013
Subject:	SHORT BREAKS FOR DISABLED CHILDREN
Classification:	Unrestricted

Summary: This report sets out the short breaks for disabled children offered in Kent, eligibility, variety, take-up and budget allocation and spend.

Recommendations: Cabinet Committee members are asked to Note and Comment on the report.

1. Introduction

1(1) The Government Aiming High programme from 2008-2011, for which Kent was a Pathfinder authority, gave opportunities through both revenue and capital funding for a substantial increase in the number and range of short breaks and the upgrading and building of new facilities for disabled children.

1(2) Since then the Breaks for Carers of Disabled Children Regulations (April 2011) has made it a duty on every local authority to provide a range of services to assist carers and to publish a statement about how they will provide short breaks, which cover day-time care, overnight care, leisure activities outside the home and support to carers in the home at evenings, weekends and during school holidays. This report sets out how we are currently meeting this requirement across Kent.

2. Financial Implications

2(1) Using the Early Intervention Grant as well as base budgets Kent County Council continues to make significant investment in services for disabled children, not only through our own resources but also through partnerships with Health, parent-led organizations and the Voluntary Sector, which enables families to be supported in the care of their disabled children, reducing stress and the number of children who become subject to Child Protection plans or require to be Looked After. The overall budget for the Disabled Children Service for 2012-13, including the in-house overnight short breaks units, is £18.142m.

2(2) Previously, members had queried the reported -£320k forecast underspend on short breaks for disabled children reported at the end of Quarter 1. As at the end of Q2, the overall forecast underspend on this budget has increased slightly to -£358k on a net budget of £2.07m.

2(3) As well as covering directly commissioned short breaks, this budget includes both independent sector day care and other related spend such as the Multi Agency Specialist Hubs (MASH) for disabled children. The -£358k forecast underspend is made up of a -£500k forecast underspend on core activity, a -£46k forecast underspend on independent sector day care and a +£188k forecast overspend on the MASH.

2(4) This underspend on directly commissioned services is expected as increasing numbers of parents and carers are choosing the option of direct payments to meet the needs of their children rather than directly commissioned service. As at the end of Q2, there is a forecast budget pressure of +£492k on direct payments, on a net budget of £2.85m.

2(5) When direct payments to parents of disabled children are included in the overall spend on disabled children there is a forecast overspend.

3 Bold Steps for Kent and Policy Framework

3(1) The short breaks provided to families through Direct Payments and the partnerships with parent-led organizations and the Voluntary Sector contribute to the aim to give citizens control over their own lives, determining what services they require and how they will organize them. It also meets the need to tackle disadvantage as disabled people, including disabled children and their families, frequently experience discrimination and exclusion from society.

3(2) The multi-agency approach is to provide services that enable disabled children to live “as normal a life as possible” providing the levels of support required to enable them to do so. The responsibility is a shared one and is being incorporated into both the SEN and the Disabled Children Strategies, currently being worked on.

4. Short Breaks Services

4(1) Short breaks are provide in five categories – mainstream/ universal, targeted, specialist by referral, multi-agency children’s continuing care packages, and supporting services.

4(1)(a) Mainstream/Universal

A key element of our short breaks planning is to support services such as leisure centres, youth clubs, children’s centres, District Council playschemes, to include disabled children. Children may need support to access these.

4(1)(b) **Targeted**

These services are aimed at disabled children whose needs are less complex than those of children who require a more specialist service. Children may choose to be with their disabled peers for some activities, as opposed to being included in a mainstream setting. Services such as holiday playschemes, afterschool clubs, befriending services fall into this category and families can access them directly rather than coming through the specialist Disabled Children's teams. The majority of these services are commissioned from the Voluntary Sector including parent-led groups.

4(1)(c**)** **Specialist**

These services are aimed at children with a severe and complex level of disability whose needs are over and above what can be met by universal or targeted provision. Access to some of these services is by referral from a specialist social worker from Kent County Council's Disabled Children's Service, or a key health professional. Our overnight short break units and short break foster carers fall into this category as do those children who are eligible to receive a Direct Payment to purchase their own care.

4(1)(d) **Multi-Agency Children's Continuing Care Packages**

There is a need for a small group of disabled children who have highly complex health, social care and education needs to receive a children's continuing care package and these are commissioned and funded jointly with Health and Education colleagues.

4(1)(e) **Supporting Services**

Some children may need support to access mainstream services e.g. a befriender accompanying them. This support may be temporary, until the service is confident it can successfully include a child. In some cases, where the needs of a child are more complex, support may be more long term.

These are the principles by which we organize services

4(1)(f) **Families' Experience of Service Planning and Provision**

The outworking of our short breaks statement in practice is illustrated by the following information:

- There are 11, 500 children in Kent in receipt of some form of Disability Living Allowance, both Care and Mobility allowances.

- An estimated 7,000 disabled children in Kent will receive short breaks this year – afterschool clubs, holiday playschemes, befriending, Family Fun Days, support from Personal Assistants through Direct Payments, weekend fun clubs, short breaks foster care, overnight stays etc.
- We have provided in-house or commissioned a total of 520,000 hours of short breaks this year, provided by over 80 commissioned services.
- The Disabled Children's Teams are working with 1700 of the most disabled children including those with Sensory impairments.
- 765 of these families were in receipt of a Direct Payment as of November 2012 to enable them to purchase their own care and support.
- 292 children with learning disabilities aged 5-18 with the highest level of need stay overnight in one of KCC's 5 residential short break units. The service operates to a dependency criteria and consistently exceeds capacity. Families accessing this service are asked for their views via annual questionnaires and through the reviewing process and the evidence is that they are very satisfied with the service they receive. This is in part reflected in 4 of the units achieving "good" overall Ofsted ratings and 1 achieving "outstanding".
- The Disabled Children Service works closely with the voluntary sector and parent groups to develop services and plug gaps.
- 3 new Multi-Agency Specialist Hubs in East Kent have been built with co-location Government grant and KCC and NHS capital so that multi-agency teams can all be based together and provide a one-stop shop for families. Short break services are also delivered at these hubs. We will use this model to develop similar services in West Kent when we can.
- New legislation from 2014 will require Local Authorities and Health to jointly plan and commission services for disabled children and those with SEN up to the age of 25. A Pathfinder programme in Thanet is working out some of the details including Personal Budgets.
- Information for families about short break services is provided through the 5 parent-driven charities across the County. They also collate families' views about services and co-ordinate all the local services through a consortium of providers and communicate the information to families through their websites, newsletters and via other organizations.
- We have a Young Inspectors programme, a Participation Worker in one Area and regular feedback to ensure that young people's views are collected and used to inform development or changes in services
- Parents sit on a number of strategic boards, funding and interview panels to enable them to be fully involved in shaping services.

5. Conclusions

5(1) The report outlines the statutory requirement to provide short breaks to disabled children and their families and the wide variety of ways in which we are fulfilling that duty. The service is responsive to feedback from users and is constantly changing and developing ways of working in order to meet the needs of disabled children and their families.

6. Recommendations

6(1) Cabinet Committee members are asked to Note and Comment on the report.

7. Background Documents

7(1) The full Short Breaks statement is available on KCC's website:

https://shareweb.kent.gov.uk/Documents/childrens-social-services/disabled-children/short-breaks-statement.pdf

8. Contact details

This report has been prepared by:

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December 2012

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TO: **Social Care & Public Health Cabinet Committee – 11th January 2013**

BY: **Graham Gibbens, Cabinet Member for Adult Social Care and Public Health**
Jenny Whittle, Cabinet Member for Specialist Children's Services
Andrew Ireland, Corporate Director - Families and Social Care

SUBJECT: **Families & Social Care Directorate (Adult Social Care & Public Health Portfolio & Specialist Children's Services Portfolio) Financial Monitoring 2012/13**

Classification: **Unrestricted**

Summary:

Members of the Cabinet Committee are asked to note the second quarter's full budget monitoring report for 2012/13, reported to Cabinet on 3 December 2012.

FOR INFORMATION

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1. Introduction:

1.1 This is a regular report to this Committee on the forecast outturn for Families & Social Care Directorate (Adult Social Care & Public Health Portfolio & Specialist Children's Services Portfolio).

2. Background:

2.1 A detailed quarterly monitoring report is presented to Cabinet, usually in September, December and March and a draft final outturn report in either June or July. These reports outline the full financial position for each portfolio and will be reported to Cabinet Committees after they have been considered by Cabinet. In the intervening months an exception report is made to Cabinet outlining any significant variations from the quarterly report. The Families & Social Care directorate annexes (one for Children's Services and one for Adult Services) from the second quarter's monitoring report for 2012/13 are attached.

3. Families & Social Care Directorate/Portfolio 2012/13 Financial Forecast - Revenue

3.1 There are no exceptional revenue changes since the writing of the attached quarter 2 report.

3.2. The table below shows a summary of the overall forecast position for the FSC directorate at the end of the second quarter of 2012-13:

Portfolio	Forecast Variance £m
Specialist Children's Services (excl EY)*	+8.283
Adult Social Care & Public Health	-2.697
Directorate Total	**+5.586**

** The Early Years and Childcare budget line is within the remit of the Education Cabinet Committee and not the Social Care & Public Health Cabinet Committee*

3.3. The table below summarise the forecast variances for Specialist Children's Services.

	Variance £m
Looked After - Residential Care	+2.269
- Fostering	+3.307
- Legal Costs	+0.285
Adoption	+0.432
Children's Staffing	+0.156
Safeguarding	+0.143
Preventative Services	-1.507
Leaving Care	-0.078
Directorate Mgt & Support	-0.084
Asylum	+3.000
Children's Centres	+0.360
Specialist Children's Service Total	+8.283

The detail and reasons of these variances can be found in the full monitoring report (Annex 2) attached, between pages 4 and 20.

3.4 The table below summarise the forecast variance for Adult Social Care and Public Health.

	Variance £m
Older People	-0.619
Physical Disability	-1.350
Learning Disability	-0.455
Mental Health	-0.113
Assessment of Vulnerable Adults	-0.452
Safeguarding	-0.054
Directorate & Management Support	+0.346
Public Health	0.000
Adult Social Care & Public Health Total	-2.697

The detail and reasons of these variances can be found in the full monitoring report (Annex 3) attached, between pages 21 and 49.

4. Families & Social Care Directorate/Portfolio 2012/13 Financial Forecast - Capital

4.1 There are no capital movements from the attached quarter 2 report.

4.2 The table below shows a summary of the overall forecast position for the FSC directorate at the end of the second quarter of 2012-13:

	Portfolio		
	Adult Social Care & Public Health £m	Specialist Children's Services £m	**TOTAL £m**
Unfunded variance	0.000	+1.118	+1.118
Funded variance	+0.030	0.000	+0.030
Variance to be funded from revenue	0.000	+0.066	+0.066
Project underspend	0.000	0.000	0.000
Re-phasing (beyond 2012/15)	-1.418	0.000	-1.418
Total variance	**-1.388**	**+1.184**	**-0.204**

5. Social Care Debt Monitoring

5.1 The latest position on social care debt can be seen in Annex 3 attached (Pages 48 – 49)

6. Recommendations

6.1 Members of the Social Care & Public Health Cabinet Committee are asked to note the revenue and capital forecast variances from budget for 2012/13 for the Families & Social Care Directorate (Adult Social Care & Public Health and Specialist Children's Services Portfolios) based on the second quarter's full monitoring to Cabinet.

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Background documents: *none*

FAMILIES & SOCIAL CARE DIRECTORATE SUMMARY
CHILDREN'S SERVICES SUMMARY
SEPTEMBER 2012-13 FULL MONITORING REPORT

1. FINANCE

1.1 REVENUE

1.1.1 All changes to cash limits are in accordance with the virement rules contained within the constitution, with the exception of those cash limit adjustments which are considered "technical adjustments" ie where there is no change in policy, including:

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits for the A-Z service analysis have been adjusted since the quarter 1 report to reflect the agreed split of the Early Years and Childcare budget, with a transfer of -£3.192m from the SCS portfolio within this directorate to the ELS portfolio/directorate reported in annex 1, leaving only the budget for 'Children's Centre Development' within the SCS portfolio within this directorate. There have also been a number of other technical adjustments to budget.
- The inclusion of a number of 100% grants (ie grants which fully fund the additional costs) awarded since the budget was set. These are detailed in Appendix 1 to the executive summary.

1.1.2 **Table 1** below details the revenue position by A-Z budget:

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Specialist Children's Services portfolio							
Strategic Management & Directorate Support Budgets	4,436	-175	4,261	-84		-84	
Children's Services:							
- Education & Personal							
- Children's Centres	17,630	0	17,630	475	-115	360	Various
- Early Years & Childcare	533	0	533	-300		-300	release of uncommitted budget
- Virtual School Kent	2,641	-704	1,937	56	-6	50	
	20,804	-704	20,100	231	-121	110	
- Social Services							
- Adoption	8,321	-49	8,272	432		432	Increase in placements, SGO
- Asylum Seekers	14,901	-14,621	280	123	2,877	3,000	forecast shortfall in funding, awaiting resolution with Govt
- Childrens Support Services	2,480	-1,043	1,437	107	55	162	OOH team staffing
- Fostering	34,320	-237	34,083	3,312	-5	3,307	Increase in demand reduced unit cost, enhanced payments, related reward payment, increase in staffing
- Leaving Care (formerly 16+)	5,127	0	5,127	-78		-78	
- Legal Charges	6,315	0	6,315	285		285	Increased demand
- Preventative Children's Services	19,537	-4,370	15,167	-1,507		-1,507	reduction in S17 payments, MASH lease, delay in investment in prevention strategy spend
- Residential Children's Services	13,750	-2,144	11,606	2,307	-38	2,269	Increase in weeks/lower unit cost, high cost placements

The Early Years and Childcare line is shaded out as this is within the remit of the Education Cabinet Committee and not the Social Care & Public Health Cabinet Committee.

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
- Safeguarding	4,637	-316	4,321	178	-35	143	Staffing
	109,388	-22,780	86,608	5,159	2,854	8,013	
Assessment Services							
- Children's Social Care Staffing	39,172	-819	38,353	-73	17	-56	
Total SCS portfolio	**173,800**	**-24,478**	**149,322**	**5,233**	**2,750**	**7,983**	
Assumed Management Action							
- SCS portfolio						**0**	
Forecast after Mgmt Action				**5,233**	**2,750**	**7,983**	

1.1.3 **Major Reasons for Variance**: *[provides an explanation of the 'headings' in table 2]*

Table 2, at the end of this section, details all forecast revenue variances over £100k. Each of these variances is explained further below:

Specialist Children's Services portfolio:

Specialist Children's Services is currently going through a restructure and cash limits will need to be realigned later in the year once the new structure is finalised and in place. This will impact on the variances reflected within this report against the individual budget lines of the SCS Portfolio, but not on the overall position for the portfolio.

1.1.3.1 Children's Centres: Net +£360k (+£475k Gross, -£115k Income)

There is a forecast gross pressure on Children's Centres of +£360k, this is due to various small variances spread over the 97 centres. We are in the process of reviewing this pressure. There is also a further gross pressure of +£115k which has a corresponding income variance -£115k, which relates to where the centres receive income for shared costs, rental of rooms, activities etc, all of which also incur expenditure.

1.1.3.2 Early Years & Childcare: Gross -£300k

An underspend of -£300k has been forecast on the Early Years, Children's centre development team from the release of uncommitted budget to offset pressures elsewhere within SCS.

1.1.3.3 Adoption: Gross +£432k

The current forecast variance of +£432k includes a pressure of +£168k for an increase in the cost of placements. In addition, there is a pressure of +£264k relating to special guardianship orders (SGO), this is due to the need to secure a permanent placement for a child where adoption is not suitable or required.

1.1.3.4 Asylum Seekers – Net +£3,000k (+£123k gross, +£2,877k income)

We are now forecasting a potential net pressure of £3,000k against the Asylum Service. This pressure is in respect of both unaccompanied asylum seeking children and those eligible under the care leaving legislation.

At this stage Kent is still to receive notification of the Gateway Grant, but this reported position assumes the same level of funding as we received in 2011-12.

Kent, along with Hillingdon and Solihull Councils, have jointly written to the Minister of State for Immigration expressing their continued frustration of not being able to agree a resolution that ensures adequate funding levels.

Until there is more certainty around a resolution it is prudent to report this pressure, but at time of writing no response had been received from the Minister. The council will continue to press the government vigorously, along with other key affected councils, to agree a means of funding which enables the Council to meet its obligations to the young people affected, but which is also fair to local residents.

1.1.3.5 Children's Support Services: Net +£162k (+£107k Gross, +£55k Income)

There is a forecast pressure on staffing of +£150k which is for the Out of Hours team, there are also other small gross variances of -£43k, and a small income variance of +£55k.

1.1.3.6 Fostering: Net +£3,307k (+£3,312k Gross, -£5k Income)

Non-related fostering (in house) is forecasting a gross pressure of +£656k, as a result of the forecast number of weeks of service being 1,065 higher than the affordable level of 54,872, this generates £402k of current pressure. Additionally the unit cost being -£2.57 lower than previously estimated when setting the cash limit has reduced the pressure by -£150k. There are also provisions within this forecast of +£186k for the potential implications of enhanced payments for carers of disabled children and +£235k of costs which were originally included within the Section 17 budget, but have been re-classified as fostering costs (see section 1.1.3.9). There are also various small underspends totalling -£17k, and a small income variance of -£5k.

Independent fostering is forecasting a gross pressure of +£2,328k. Again this is as a result of an increase in weeks support, which is 3,176 higher than the affordable level of 6,152 and results in a pressure of +£2,897k. However, the average weekly cost is £92.71 lower than budgeted, and this reduces the total pressure by -£569k

A gross underspend of -£577k is forecast on Kinship non LAC which is due to reduced demand. This reduction in spend has resulted in an increase in the SGO forecast of +£264k (in section 1.1.3.3 above) and +£320k on related foster payments (see below), and other small variances of -£7k.

There is a forecast gross pressure on Related foster payments of +£757k, of which +£437k is due to new legislation that came into effect on the 1st April 2011 which requires Local Authorities to pay reward payments to related foster carers. Kent's policy was that related carers only receive the maintenance element, whereas non-related carers receive both a maintenance and a fee element. At the time of calculating pressures for the 2012-13 budget Kent felt that this legislation was ambiguous, and sought legal advice to clarify our position. We have since had confirmation that we must apply this. The remaining +£320k is due to an increase in demand resulting from the drive to move children from Kinship to Related foster payments (and SGO see section 1.1.3.3).

The county fostering team is forecasting a gross pressure of +£148k, due to an increase in the number of staff following the restructure.

1.1.3.7 Leaving Care (formerly 16+): Gross -£78k

An underspend of -£477k is forecast on leaving care/Section 24. This is partly due to fewer than anticipated 16-18 year olds using this service as they are remaining in foster care, and also stricter controls around S24 payments (*assistance provided to a child aged 16+ who leaves local authority care*). There is also a forecast pressure of +£295k due to a VAT liability dating back to 2009 relating to the contract with Catch 22. In addition there are other small variances totalling +£104k.

1.1.3.8 Legal Charges: Gross +£285k

There is a pressure forecast on the legal budget of +£285k, of which +£135k is due to demand being greater than that budgeted for and +£150k is spend which has moved from the Section 17 budget (see section 1.1.3.9)

1.1.3.9 Preventative Children's Services: Gross -£1,507k

There is a forecast underspend of -£929k on the Section 17 *(Provision of services for children in need, their families and others)* budget. -£235k of this is due to spend being re-classified as fostering costs and a further -£150k has been re-classified as legal costs, both of which had previously been classified as Section 17. These costs are now included in sections 1.1.3.6 and 1.1.3.8 respectively. Please note that budgets will be realigned as part of the SCS restructure to reflect this change in classification. A further underspend has been forecast of -£565k due to management action and more detailed guidance being issued to district teams on when they can make Section 17 payments. There are also other small gross variances of +£21k on the section 17 budget.

There is a forecast underspend of -£140k on Independent sector day care and short breaks as a result of renegotiated day care costs.

Independent sector day care and short breaks for disabled children has a forecast underspend of -£358k, of which there is an underspend of -£500k on core activity as a result of a shift to providing direct payments instead (see below). In addition there is a forecast pressure of +£188k due to lease charges on the MASH (Multi Agency Specialist Hubs). There are other small variances totalling -£46k on independent sector day care for disabled children.

There is a forecast underspend of -£500k on the investment in prevention strategy budget allocated in the 12-15 MTFP due to a delay in the business cases and projects.

Direct payments has a forecast pressure of +£492k, this is due to the number of forecast weeks being 5,845 higher than budgeted, and the forecast rate being £7.25 higher than the budgeted rate.

There are also other small variances totalling -£72k

1.1.3.10 Residential Children's Services: Net +£2,269k (+£2,307k Gross, -£38k Income)

Of the pressure within residential services, +£2,022k (+£1,875k Gross, +£147k Income) relates to non disabled independent sector residential provision. The forecast number of weeks of service is 796 higher than the affordable level of 1,892, which generates +£2,369k of current pressure. Additionally the unit cost being -£261.30 lower than previously estimated when setting the cash limit has reduced this pressure by -£494k. The income variance of +£147k is due to a reduction in income for placements from health.

The budget for independent residential care for disabled children is showing a pressure of +£321k (+£297k Gross, +£24k Income). This is due to an increase in high cost placements of +£425k, and an underspend of -£128k due to a reduction in the overall number of placements. There is also a small income variance of +£24k.

KCC residential care for disabled children shows a forecast underspend of -£230k. Of this, -£211k is due to an increase in income from District Health Authorities for an increased number of children attracting external income. The expenditure related to the DHA income is offset by lower than expected expenditure generally. There are other small gross variances totalling -£19k

There is a further forecast gross variance on Residential care for Non-LAC of +£81k due to an increase in placements, and a small income variance of +£2k.

There is also a small gross pressure forecast on secure accommodation of +£73k

1.1.3.11 Safeguarding: Gross Net +£143k (+£178k Gross, -£35k Income)

The safeguarding service is projecting a pressure of +£178k on staffing, this will be resolved as part of the SCS restructure. There is also a small income variance of -£35k

1.1.3.12 Assessment Services – Children's social care staffing – -£56k (-£73k Gross, +£17k income)

There is currently a forecast pressure on this budget of +£1,279k for the new county referral unit which has been set up in advance of the main restructure. However this is now being offset by a forecast underspend of -£1,352k on other staffing, which will be resolved as part of the SCS restructure. There is also a small income variance of +£17k.

Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER

(shading denotes that a pressure has an offsetting saving, which is directly related, or vice versa)

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
SCS	Asylum - forecast shortfall in funding, awaiting resolution with Government	+3,000	SCS	Children's social care staffing - Gross - Staffing	-1,352
SCS	Fostering - Gross - Independent - forecast weeks higher than budgeted	+2,897	SCS	Fostering - Gross - Independent - forecast unit cost lower than budgeted	-569
SCS	Residential - Gross - Non Dis Independent Sector - forecast weeks higher than budgeted	+2,369	SCS	Preventative Children's services - Gross - management action and more detailed guidance on Section 17 payments	-565
SCS	Children's social care staffing - Gross - New County Referral Unit	+1,279	SCS	Preventative Children's services - Gross - Independent sector day care dis - reduction in core activity due to a shift to direct payments	-500
SCS	Preventative Children's services - Gross - Direct Payments - Forecast weeks/unit costs higher than budgeted (shift from Ind day care disability)	+492	SCS	Preventative Children's services - Gross - delay in investment in prevention strategy spend	-500
SCS	Fostering - Gross - Related foster payments - increase in reward payments	+437	SCS	Residential - Gross - Non Dis Independent Sector - forecast unit cost lower than budgeted	-494
SCS	Residential - Gross - Dis Independent Sector - Increase in high cost placements	+425	SCS	Leaving care - Gross - decrease in demand as 16-18 yr olds remaining in foster care, stricter controls around S24 payments	-477
SCS	Fostering - Gross - Non-related in house - forecast weeks higher than budgeted	+402	SCS	Fostering - Gross - Kinship non LAC - move to related fostering	-320
SCS	Children's centres - Gross - Various small overspends	+360	SCS	Early Years - Gross - Children's centre development team - release of uncommitted budget	-300
SCS	Fostering - Gross - Related foster payments - drive to move children from Kinship to Related Fostering	+320	SCS	Fostering - Gross - Kinship non LAC - move to SGO	-264
SCS	Leaving care - Gross - VAT liability	+295	SCS	Preventative Children's services - Gross - Costs re-classified as fostering	-235
SCS	Adoption - Gross - Increase in Special Guardianship Orders	+264	SCS	Residential - Gross - KCC residential - increase in income from District Health Authorities	-211
SCS	Fostering - Gross - Non-related in house - fostering costs moved from S.17	+235	SCS	Preventative Children's services - Gross - Costs re-classified as legal costs	-150
SCS	Preventative Children's services - Gross - increased cost of MASH due to lease changes	+188	SCS	Fostering - Gross - Non-related in house - forecast unit cost lower than budgeted	-150
SCS	Fostering - Gross - Non-related in house - enhanced payments for carers of disabled children	+186	SCS	Preventative Children's services - Gross - Independent sector day care non dis- renegotiated day care rate	-140
SCS	Safeguarding - Gross - staffing	+178	SCS	Residential - Gross - Dis Independent Sector - reduction in the overall number of placements	-128

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
SCS	Adoption - Gross - Increase in cost of placements	+168	SCS	Children's centres - Income - Various income for utilities, activities etc	-115
SCS	Children's Support Services - Gross - Staffing (Out of Hours Team)	+150			
SCS	Legal Charges - Gross - costs moved from S.17	+150			
SCS	Fostering - Gross - County fostering team - increase in number of staff	+148			
SCS	Residential - Income - Non Dis Independent Sector - reduction in income for placements from Health	+147			
SCS	Legal Charges - Gross - increased demand	+135			
SCS	Children's centres - Gross - Various spend on utilities, activities etc	+115			
		+14,340			-6,470

1.1.4 **Actions required to achieve this position**:

Although there was a continued increase of looked after children between April and June, it is anticipated that a number of control measures and early intervention services which have been put in place should mean that costs overall will begin to reduce, as well as a new staffing structure. There is evidence that the looked after children numbers of children in care have begun to reduce in the second quarter as illustrated in section 2.1, however it is too early to confirm whether this trend will continue.

1.1.5 **Implications for MTFP**:

The 2013-14 budget proposals that went out for consultation had significant savings targets associated with the Looked After Children Strategy and a fundamental transformation of procedures in Children's Services. Those targets assume that the 2012-13 budget for Specialist Children's Services does not overspend.

However, as the quarter 2 position, excluding Asylum, has only improved slightly from the position reported in quarter 1, with a £4.983m pressure still reported (and a further £3m pressure reported for Asylum), there must be concern that the savings targets in the 2013-14 budget proposals that went for consultation are not achievable in full. This position is being closely monitored in order that the final proposed budget reflects a realistic forecast of spending in 2013-14.

1.1.6 **Details of re-phasing of revenue projects**:

None

1.1.7 **Details of proposals for residual variance**:

Controls have been put in place which we believe will help to reduce some of this financial pressure during the year, these include:

- *Access to Resource Panels chaired by Assistant Directors, to ensure that there is consistent decision making with regard to new placements for children in care.*
- *Placement Panels to review the status and placement of current children in care.*
- *New guidance and expenditure limits applied to Section 17 expenditure and transport costs.*
- *New commissioning framework being drawn up to reduce the costs of Independent Fostering placements.*
- *Recruitment of more in-house foster carers and potential adopters.*
- *Better contract management.*
- *Improved joint working with Legal through a Service Level Agreement.*

Structural changes are being implemented which will ensure that there are smaller teams with better management oversight, and clearer delineated accountability for case work decisions. New Access to Resources Team is being established, which will help maximise commissioning potential, and ensure best value.

In addition to the above, new commissioning frameworks have been developed for Early Intervention Services and Disabled Children's Services which will enhance early intervention, and therefore reduce the need for ongoing higher costs.

1.2 CAPITAL

1.2.1. All changes to cash limits are in accordance with the virement rules contained within the constitution and have received the appropriate approval via the Leader, or relevant delegated authority.

1.2.2 The Specialist Childrens Services portfolio has an approved budget for 2012-15 of £0.769m (see table 1 below). The forecast outturn against this budget is £1.953m, giving a variance of £1.184m. After adjustments for funded variances and reductions in funding, the revised variance comes to £1.118m (see table 3).

1.2.3 Tables 1 to 3 summaries the portfolio's approved budget and forecast.

1.2.4 Table 1 – Revised approved budget

	£m
Approved budget last reported to Cabinet	0.769
Approvals made since last reported to Cabinet	0.000
Revised approved budget	0.769

1.2.5 Table 2 – Funded and Revenue Funded Variances

Scheme	Amount £m	Reason
Cabinet to approve cash limit changes		
No cash limit changes to be made		
Ashford, Thanet & Swale MASH	0.006	Revenue contribution
Self Funded Projects - Quarry fields	0.060	Revenue contribution
Total	0.066	

1.2.6 Table 3 – Summary of Variance

	Amount £m
Unfunded variance	**1.118**
Funded variance (from table 2)	0.000
Variance to be funded from revenue (from table 2)	0.066
Rephasing (beyond 2012-15)	**0.000**
Total variance	**1.184**

Main reasons for variance

1.2.7 Table 4 below, details each scheme indicating all variances and the status of the scheme. Each scheme with a Red or Amber status will be explained including what is being done to get the scheme back to budget/on time.

1.2.8 Table 4 – Scheme Progress

Scheme Name	Total approved budget	Previous Spend	2012-15 approved budget	Later Years approved budget	2012-15 Forecast Spend	Later Years Forecast Spend	2012-15 Variance	Total Project Variance	Status Red/Amber/ Green
	£m	£m	£m	£m	£m	£m	£m	£m	
	(a) = b+c+d	(b)	(c)	(d)	(e)	(f)	(g) = e-c	(h) = b+e+f-a	
Ashford, Thanet & Swale MASH	15.826	15.843	-0.017	0.000	1.107	0.000	1.124	1.124	Amber - Overspend
TSB2 Short Breals Pathfinder Programme	0.532	0.117	0.415	0.000	0.415	0.000	0.000	0.000	Green
Early Years & Childrens Centres	41.955	41.901	0.054	0.000	0.054	0.000	0.000	0.000	Green
Self Funded Projects (Quarryfields)	0.264	0.198	0.066	0.000	0.126	0.000	0.060	0.060	Green
Service Redesign	0.251	0.000	0.251	0.000	0.251	0.000	0.000	0.000	Green
TOTAL Specialist Childrens Services	58.828	58.059	0.769	0.000	1.953	0.000	1.184	1.184	

1.2.8 Status:
Green – Projects on time and budget
Amber – Projects either delayed or over budget
Red – Projects both delayed and over budget

1.2.9 Assignment of Green/Amber/Red Status

1.2.10 Projects with variances to budget will only show as amber if the variance is unfunded, i.e. there is no additional grant, external or other funding available to fund.

1.2.11 Projects are deemed to be delayed if the forecast completion date is later than what is in the current project plan.

Amber and Red Projects – variances to cost/delivery date and why

1.2.12 MASH - Latest MASH estimates show a forecast variance of £1.124m in 2012-13. This reflects a continuing pressure and has increased by £0.024m since last reported to Cabinet mainly due to additional consultancy fees. £0.006m of the overspend is to be funded from a revenue contribution, and there is anticipated external funding of £0.800m which is awaiting confirmation from the NHS. If this is forthcoming there remains an unfunded variance of £0.318m, the funding of which is yet to be resolved.

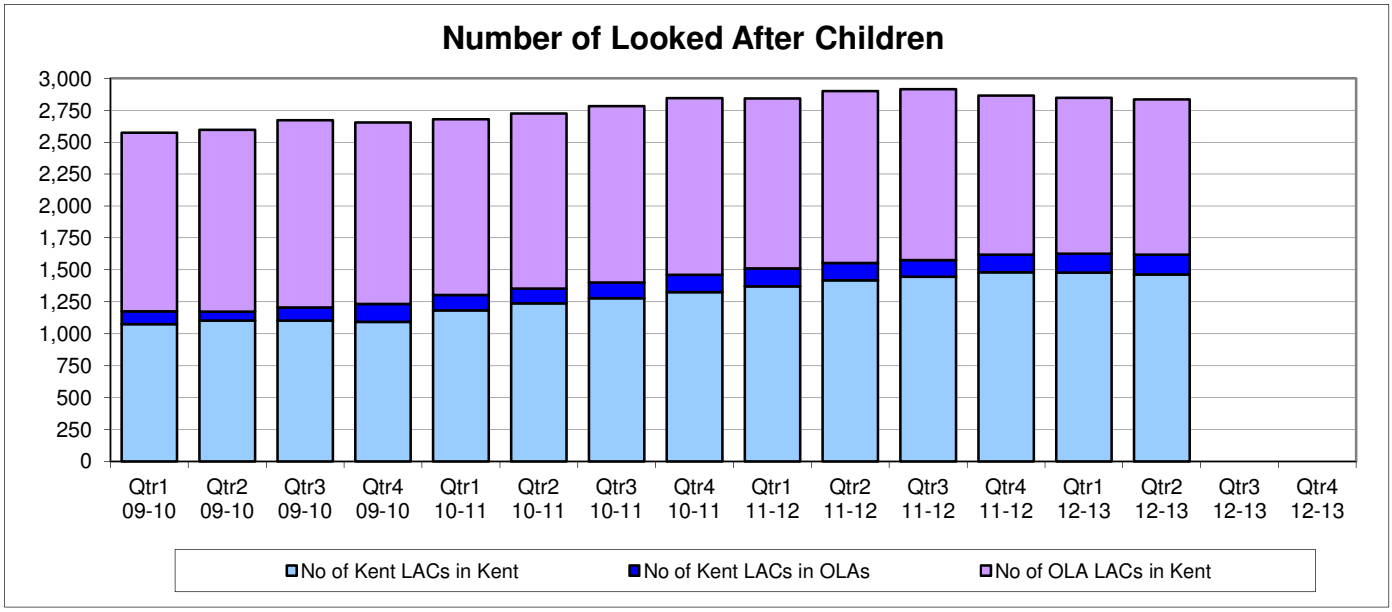
Key issues and Risks

1.2.13 MASH – until the funding of £0.800m is confirmed from the NHS there is a risk around this.

2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

2.1 **Numbers of Looked After Children (LAC)** (excluding Asylum Seekers):

	No of Kent LAC placed in Kent	No of Kent LAC placed in OLAs	TOTAL NO OF KENT LAC	No of OLA LAC placed in Kent	TOTAL No of LAC in Kent
2009-10					
Apr – Jun	1,076	100	**1,176**	1,399	**2,575**
Jul – Sep	1,104	70	**1,174**	1,423	**2,597**
Oct – Dec	1,104	102	**1,206**	1,465	**2,671**
Jan – Mar	1,094	139	**1,233**	1,421	**2,654**
2010-11					
Apr – Jun	1,184	119	**1,303**	1,377	**2,680**
Jul – Sep	1,237	116	**1,353**	1,372	**2,725**
Oct – Dec	1,277	123	**1,400**	1,383	**2,783**
Jan – Mar	1,326	135	**1,461**	1,385	**2,846**
2011-12					
Apr – Jun	1,371	141	**1,512**	1,330	**2,842**
Jul – Sep	1,419	135	**1,554**	1,347	**2,901**
Oct – Dec	1,446	131	**1,577**	1,337	**2,914**
Jan – Mar	1,480	138	**1,618**	1,248	**2,866**
2012-13					
Apr – Jun	1,478	149	**1,627**	1,221	**2,848**
Jul – Sep	1,463	155	**1,618**	1,216	**2,834**
Oct – Dec					
Jan – Mar					



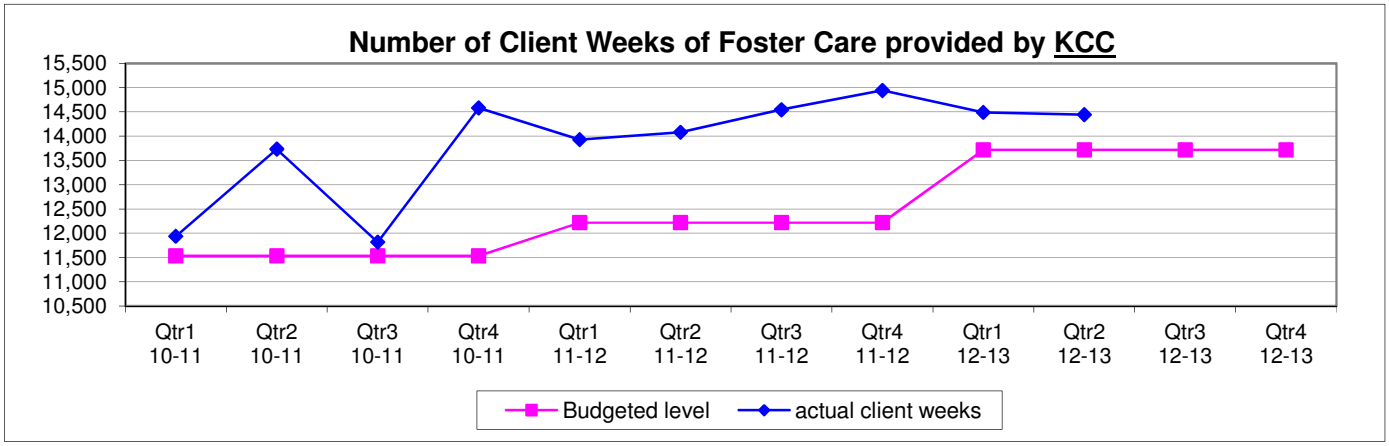
Comments:

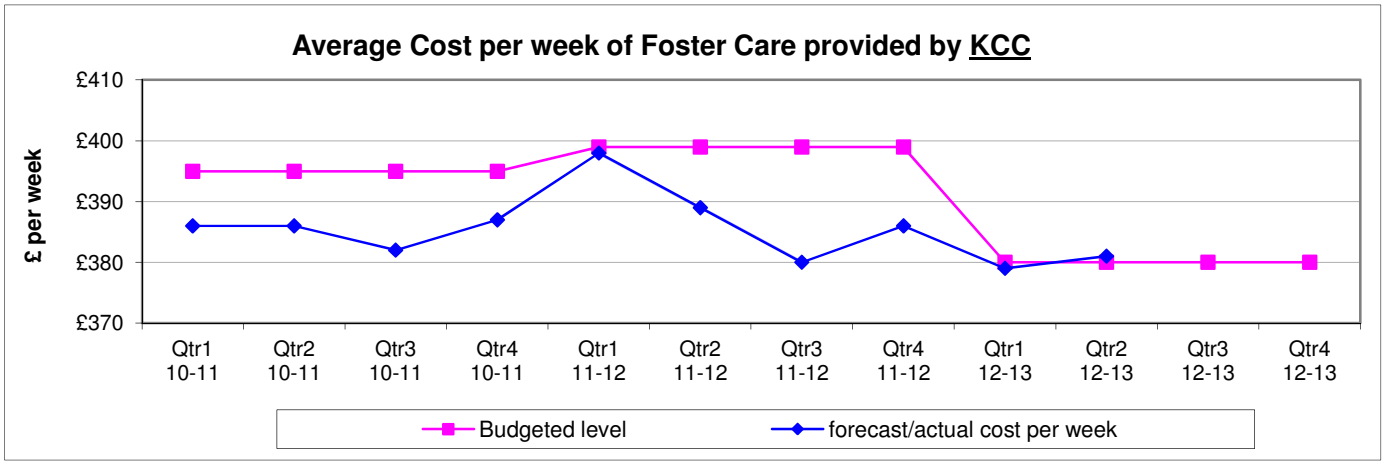
- Children Looked After by KCC may on occasion be placed out of the County, which is undertaken using practice protocols that ensure that all long-distance placements are justified and in the interests of the child. All Looked After Children are subject to regular statutory reviews (at least twice a year), which ensures that a regular review of the child's care plan is undertaken.
- The number of looked after children for each quarter represents a snapshot of the number of children designated as looked after at the end of each quarter, it is not the total number of looked after children during the period. Therefore although the number of Kent looked after children has reduced by 9 this quarter, there could have been more (or less) during the period.
- The increase in the number of looked after children since the 12-13 budget was set has placed additional pressure on the services for looked after children, including fostering and residential care.

- The OLA LAC information has a confidence rating of 75% and is completely reliant on Other Local Authorities keeping KCC informed of which children are placed within Kent. The Management Information Unit (MIU) regularly contact these OLAs for up to date information, but replies are not always forthcoming. This confidence rating is based upon the percentage of children in this current cohort where the OLA has satisfactorily responded to recent MIU requests.

2.2.1 **Number of Client Weeks & Average Cost per Client Week of Foster Care provided by KCC**:

	2010-11				2011-12				2012-13			
	No of weeks		Average cost per client week		No of weeks		Average cost per client week		No of weeks		Average cost per client week	
	Budget Level	actual	Budget level	actual	Budget level	actual	Budget level	actual	Budget level	actual	Budget level	forecast
Apr - June	11,532	11,937	£395	£386	12,219	13,926	£399	£398	13,718	14,487	£380	£379
July - Sep	11,532	13,732	£395	£386	12,219	14,078	£399	£389	13,718	14,440	£380	£377
Oct - Dec	11,532	11,818	£395	£382	12,219	14,542	£399	£380	13,718		£380	
Jan - Mar	11,532	14,580	£395	£387	12,219	14,938	£399	£386	13,718		£380	
	46,128	**52,067**	**£395**	**£387**	**48,876**	**57,484**	**£399**	**£386**	**54,872**	**28,927**	**£380**	**£377**





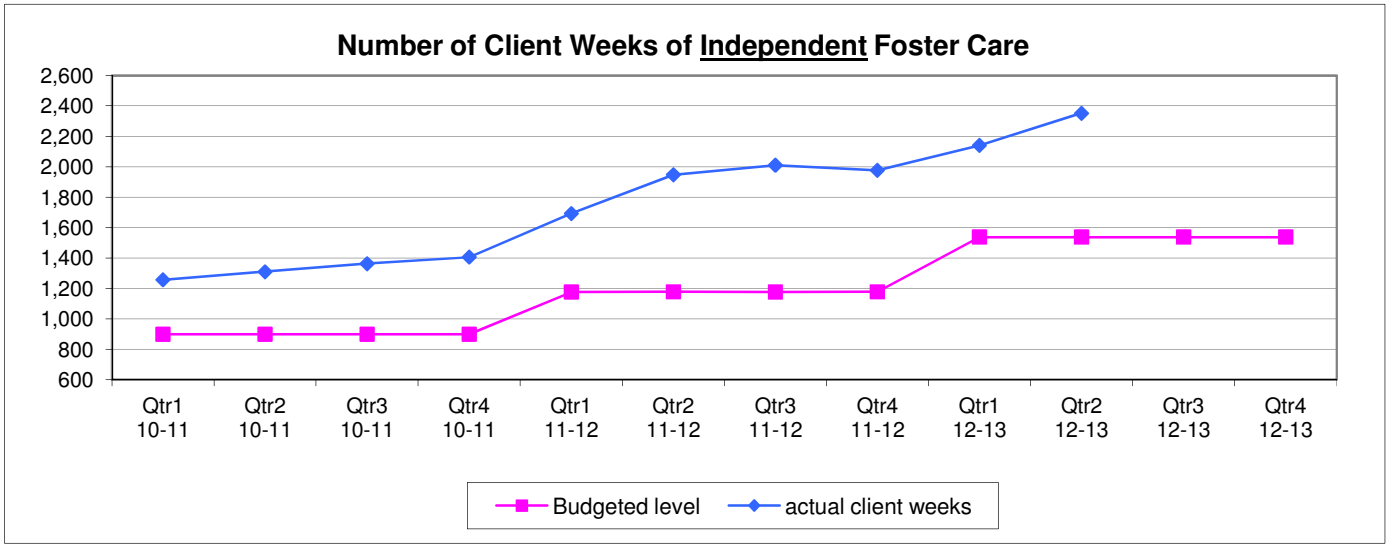
Comments:

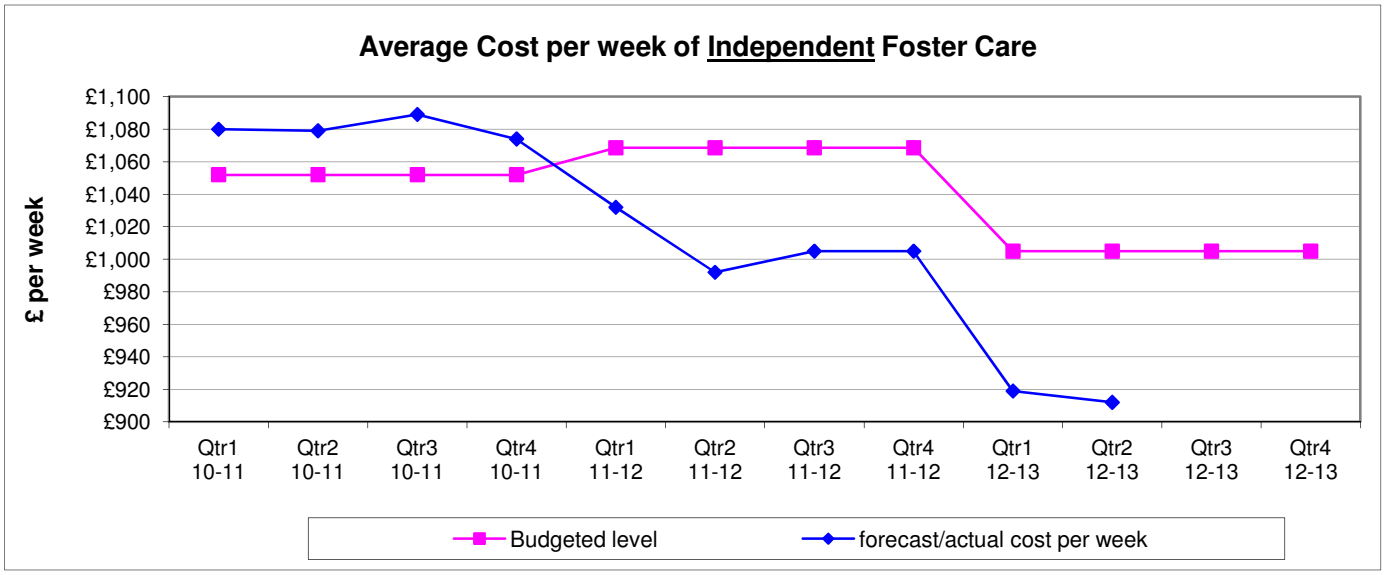
- The actual number of client weeks is based on the numbers of known clients at a particular point in time. This may be subject to change due to the late receipt of paperwork.
- The budgeted level has been calculated by dividing the budget by the average weekly cost. The average weekly cost is also an estimate based on financial information and estimates of the number of client weeks and may be subject to change.
- In addition, the 2012-13 budgeted level represents the level of demand as at the 2011-12 3rd quarter's full monitoring report, which is the time at which the 2012-13 budget was set and approved. However, since that time, the service has experienced continued demand on this service.

- The forecast number of weeks is 55,937 (excluding asylum), which is 1,065 weeks above the affordable level. This forecast number of weeks is lower than the YTD activity would suggest due to an anticipated reduction in the number of children in in-house fostering for the remainder of the year in response to the controls put in place to help reduce the pressures on the SCS budgets (see section 1.1.7), and problems finding suitable in-house placements. At the forecast unit cost of £377.25 per week, this increase in activity gives a pressure of £402k.
- The forecast unit cost of £377.25 is -£2.75 below the budgeted level and when multiplied by the budgeted number of weeks, gives an underspend of -£150k.
- Overall therefore, the combined gross pressure on this service for both under and over 16's (and those with a disability) is +£252k (£402k - £150k), as reported in sections 1.1.3.6.

2.2.2 **Number of Client Weeks & Average Cost per Client Week of Independent Foster Care**:

	2010-11				2011-12				2012-13			
	No of weeks		Average cost per client week		No of weeks		Average cost per client week		No of weeks		Average cost per client week	
	Budget Level	actual	Budget level	actual	Budget level	actual	Budget level	actual	Budget level	actual	Budget level	forecast
Apr - June	900	1,257	£1,052	£1,080	1,177	1,693	£1,068.60	£1,032	1,538	2,141	£1,005	£919
July - Sep	900	1,310	£1,052	£1,079	1,178	1,948	£1,068.60	£992	1,538	2,352	£1,005	£912
Oct - Dec	900	1,363	£1,052	£1,089	1,177	2,011	£1,068.60	£1,005	1,538		£1,005	
Jan - Mar	900	1,406	£1,052	£1,074	1,178	1,977	£1,068.60	£1,005	1,538		£1,005	
	3,600	**5,336**	**£1,052**	**£1,074**	**4,710**	**7,629**	**£1,068.60**	**£1,005**	**6,152**	**4,493**	**£1,005**	**£912**



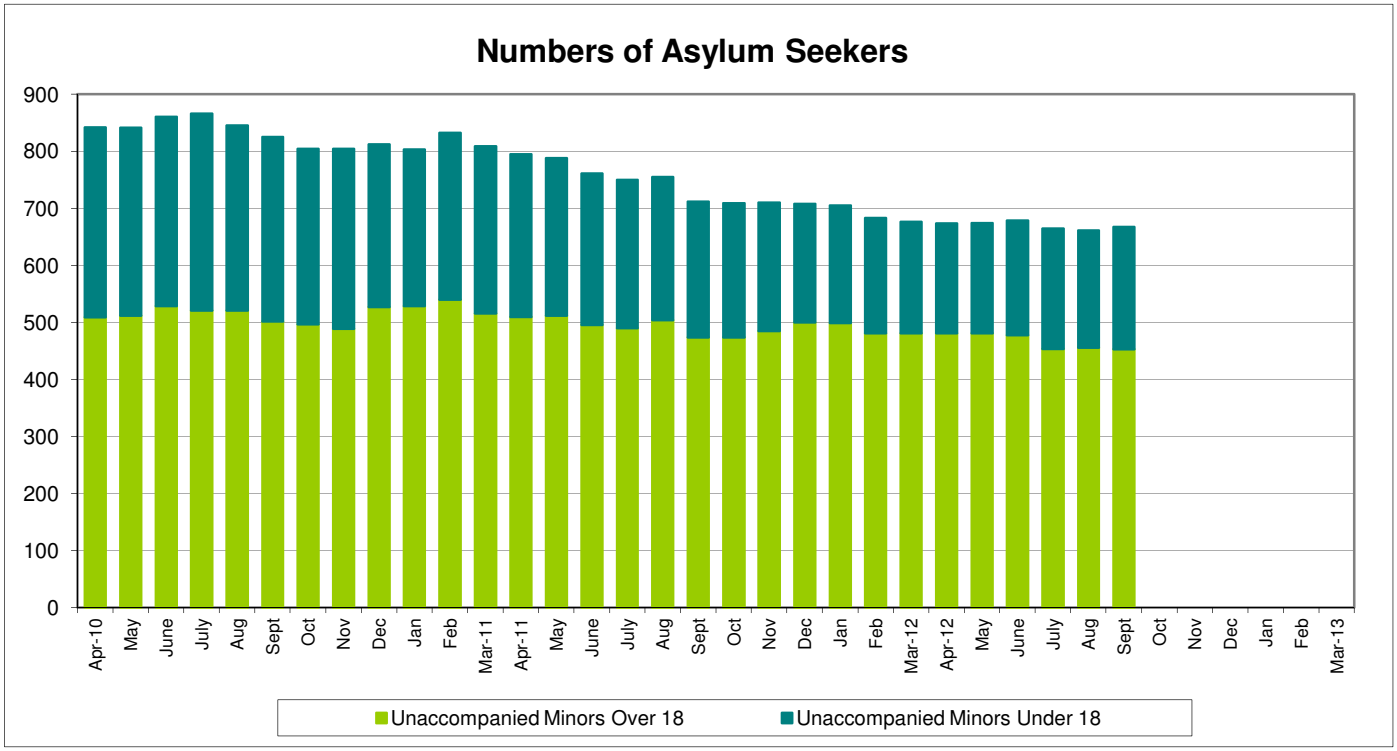


Comments:

- The actual number of client weeks is based on the numbers of known clients at a particular point in time. This may be subject to change due to the late receipt of paperwork.
- The budgeted level has been calculated by dividing the budget by the average weekly cost. The average weekly cost is also an estimate based on financial information and estimates of the number of client weeks and may be subject to change.
- For the 2012-13 budget further significant funding has been made available based on the actual level of demand at the 3rd quarter's monitoring position for 2011-12, the time at which the 2012-13 budget was set and approved. However, since that date the service has experienced continued demand on this service.
- The forecast number of weeks is 9,328 (excluding asylum), which is 3,176 weeks above the affordable level. The forecast number of weeks is higher than the YTD activity would suggest due to an increase in the number of IFA placements reflecting the difficulty in finding in-house placements. At the forecast unit cost of £912.29, this increase in activity give a pressure of £2,897k.
- The forecast unit cost of £912.29 is an average and is -£92.71 below the budgeted level and when multiplied by the budgeted number of weeks gives a saving of -£569k
- Overall therefore, the combined forecast gross pressure on this service and is +£2,328k (+£2,897k increased demand and -£569k lower unit cost), as reported in sections 1.1.3.6.

2.3 **Numbers of Unaccompanied Asylum Seeking Children (UASC)**:

	2010-11			2011-12			2012-13		
	Under 18	Over 18	**Total Clients**	Under 18	Over 18	**Total Clients**	Under 18	Over 18	**Total Clients**
April	333	509	**842**	285	510	**795**	192	481	**673**
May	329	512	**841**	276	512	**788**	193	481	**674**
June	331	529	**860**	265	496	**761**	200	478	**678**
July	345	521	**866**	260	490	**750**	210	454	**664**
August	324	521	**845**	251	504	**755**	205	456	**661**
September	323	502	**825**	238	474	**712**	214	453	**667**
October	307	497	**804**	235	474	**709**			
November	315	489	**804**	225	485	**710**			
December	285	527	**812**	208	500	**708**			
January	274	529	**803**	206	499	**705**			
February	292	540	**932**	202	481	**683**			
March	293	516	**809**	195	481	**676**			

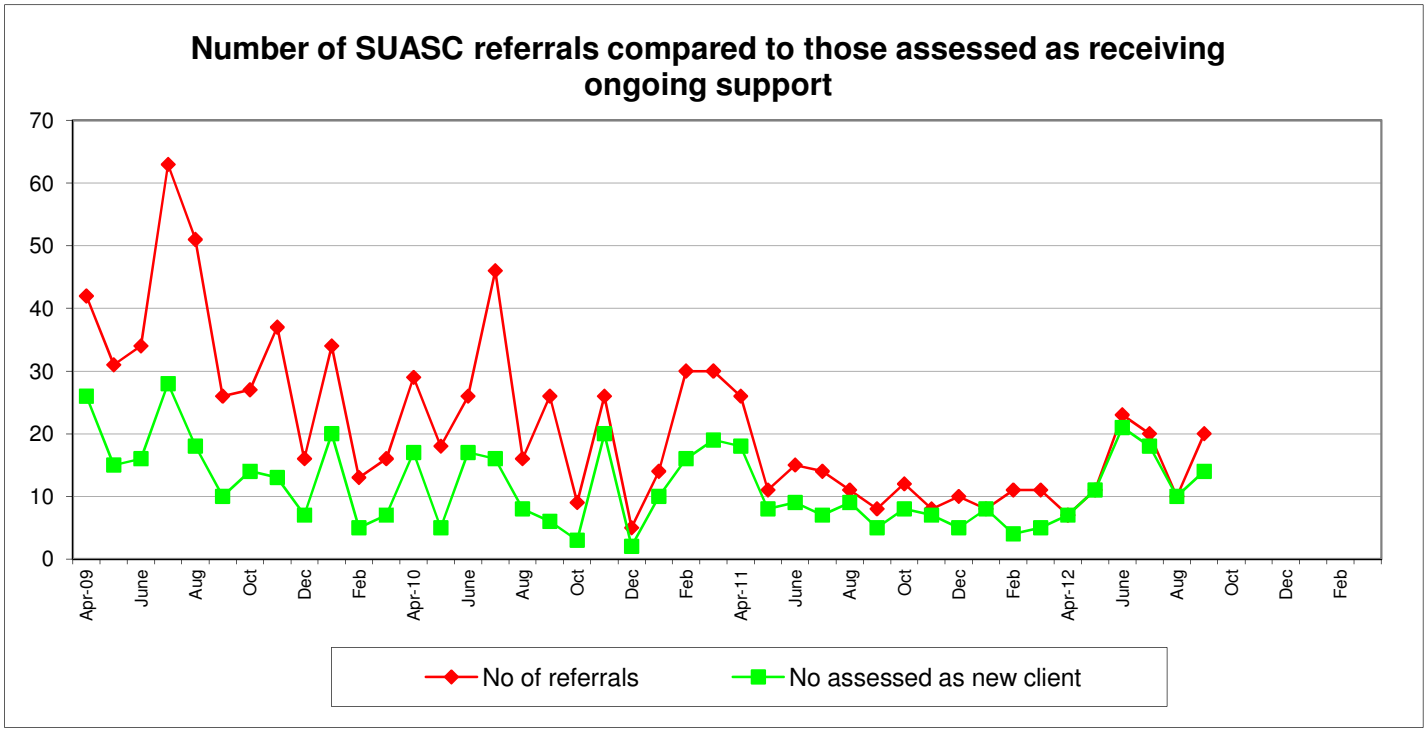


Comment:

- The overall number of children has remained fairly static so far this year. The current number of clients supported is below the budgeted level of 690.
- The budgeted number of referrals for 2012-13 is 15 per month, with 9 (60%) being assessed as under 18.
- Despite improved partnership working with the UKBA, the numbers of over 18's who are All Rights of appeal Exhausted (ARE) have not been removed as quickly as originally planned.
- In general, the age profile suggests the proportion of over 18s is decreasing slightly and, in addition, the age profile of the under 18 children has increased
- The data recorded above will include some referrals for which the assessments are not yet complete or are being challenged. These clients are initially recorded as having the Date of Birth that they claim but once their assessment has been completed, or when successfully appealed, their category may change.

2.4 **Numbers of Asylum Seeker referrals compared with the number assessed as qualifying for on-going support from Service for Unaccompanied Asylum Seeking Children (SUASC) ie new clients**:

	2009-10			2010-11			2011-12			2012-13		
	No. of referrals	No. assessed as new client	%	No. of referrals	No. assessed as new client	%	No. of referrals	No. assessed as new client	%	No. of referrals	No. assessed as new client	%
April	42	26	62%	29	17	59%	26	18	69%	7	7	100%
May	31	15	48%	18	5	28%	11	8	73%	11	11	100%
June	34	16	47%	26	17	65%	15	9	60%	23	21	91%
July	63	28	44%	46	16	35%	14	7	50%	20	18	90%
Aug	51	18	35%	16	8	50%	11	9	82%	10	10	100%
Sept	26	10	38%	26	6	23%	8	5	62%	20	14	70%
Oct	27	14	52%	9	3	33%	12	8	67%			
Nov	37	13	35%	26	20	77%	8	7	88%			
Dec	16	7	44%	5	2	40%	10	5	50%			
Jan	34	20	59%	14	10	71%	8	8	100%			
Feb	13	5	38%	30	16	53%	11	4	36%			
Mar	16	7	44%	30	19	63%	11	5	45%			
	390	**179**	**46%**	**275**	**139**	**51%**	**145**	**93**	**64%**	**91**	**81**	**89%**

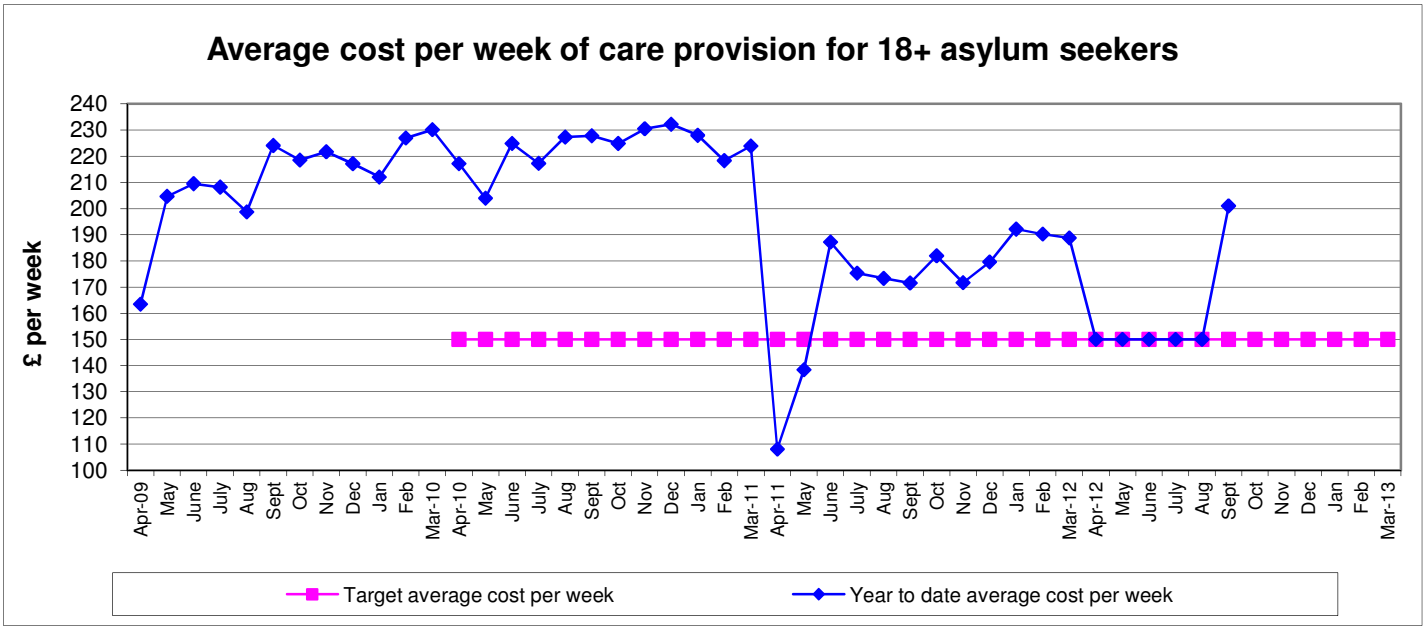


Comments:

- In general, referral rates have been lower since September 2009 which coincides with the French Government's action to clear asylum seeker camps around Calais. The average number of referrals per month is now 15, which equals the budgeted number of 15 referrals per month.
- The number of referrals has a knock on effect on the number assessed as new clients. The budgeted level is based on the assumption 60% of the referrals will be assessed as a new client. The average number assessed as new clients is now 89%.
- The budget assumed 9 new clients per month (60% of 15 referrals) but the average number of new clients per month is currently 13.5 i.e a 50% increase.

2.5 **Average monthly cost of Asylum Seekers Care Provision for 18+ Care Leavers:**

	2009-10		2010-11		2011-12		2012-13	
	Target average weekly cost £p	Year to date average weekly cost £p	Target average weekly cost £p	Year to date average weekly cost £p	Target average weekly cost £p	Year to date average weekly cost £p	Target average weekly cost £p	Year to date average weekly cost £p
April		163.50	150.00	217.14	150.00	108.10	150.00	150.00
May		204.63	150.00	203.90	150.00	138.42	150.00	150.00
June		209.50	150.00	224.86	150.00	187.17	150.00	150.00
July		208.17	150.00	217.22	150.00	175.33	150.00	150.00
August		198.69	150.00	227.24	150.00	173.32	150.00	150.00
September		224.06	150.00	227.79	150.00	171.58	150.00	200.97
October		218.53	150.00	224.83	150.00	181.94	150.00	
November		221.64	150.00	230.47	150.00	171.64	150.00	
December		217.10	150.00	232.17	150.00	179.58	150.00	
January		211.99	150.00	227.96	150.00	192.14	150.00	
February		226.96	150.00	218.30	150.00	190.25	150.00	
March		230.11	150.00	223.87	150.00	188.78	150.00	



Comments:

- The local authority has agreed that the funding levels for the unaccompanied Asylum Seeking childrens Service 18+ grant Asylum Service agreed with the Government rely on us achieving an average cost per week of £150, in order for the service to be fully funded, which is also reliant on the UKBA accelerating the removal process. In 2011-12 UKBA changed their grant rules and now only fund the costs of an individual for up to three months after the All Rights of appeal Exhausted (ARE) process if the LA carries out a Human Rights Assessment before continuing support. The LA has continued to meet the cost of the care leavers in order that it can meet it statutory obligations to those young people under the Leaving Care Act until the point of removal.
- As part of our partnership working with UKBA, most UASC in Kent are now required to report to UKBA offices on a regular basis, in most cases weekly. The aim is to ensure that UKBA have regular contact and can work with the young people to encourage them to make use of the voluntary methods of return rather than forced removal or deportation. As part of this arrangement any young person who does not report as required may have their Essential living allowance discontinued. As yet this has not resulted in an increase in the number of AREs being removed. The number of AREs supported has continued to remain steady, but high. Moving clients on to the pilot housing scheme was slower than originally anticipated, however all our young people, who it was appropriate to move to lower cost accommodation, were moved by the end of 2010-11. However there remain a number of issues:

- For various reasons, some young people have not yet moved to lower cost properties, mainly those placed out of county. These placements are largely due to either medical/mental health needs or educational needs.
- We are currently experiencing higher than anticipated level of voids, properties not being fully occupied. Following the incident in Folkestone in January 2011, teams are exercising a greater caution when making new placements into existing properties. This is currently being addressed by the Accommodation Team.
- We are still receiving damages claims relating to closed properties.

- As part of our strive to achieve a net unit cost of £150 or below, we will be insisting on take-up of state benefits for those entitled.

FAMILIES & SOCIAL CARE DIRECTORATE SUMMARY
ADULTS SERVICES SUMMARY
SEPTEMBER 2012-13 FULL MONITORING REPORT

1. FINANCE

1.1 REVENUE

1.1.1 All changes to cash limits are in accordance with the virement rules contained within the constitution, with the exception of those cash limit adjustments which are considered "technical adjustments" ie where there is no change in policy, including:

- Allocation of grants and previously unallocated budgets where further information regarding allocations and spending plans has become available since the budget setting process.
- Cash limits for the A-Z service analysis have been adjusted since the quarter 1 monitoring report to reflect a number of technical adjustments to budget including the centralisation of training budgets and room hire budgets.
- The inclusion of a number of 100% grants (ie grants which fully fund the additional costs) awarded since the budget was set. These are detailed in Appendix 1 of the executive summary.

1.1.2 **Table 1** below details the revenue position by A-Z budget:

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
Adult Social Care & Public Health portfolio							
Strategic Management & Directorate Support Budgets	9,968	-1,069	8,899	369	-23	346	Estimated legal charge pressure; staffing pressure
Adults & Older People:							
- Direct Payments							
- Learning Disability	12,769	-547	12,222	-973	272	-701	Activity below budget level; income unit charge lower than budget
- Mental Health	710	0	710	4	0	4	
- Older People	6,924	-787	6,137	-625	-7	-632	Activity & unit cost below budget level
- Physical Disability	9,580	-374	9,206	-384	-73	-457	Activity below budget level
Total Direct Payments	29,983	-1,708	28,275	-1,978	192	-1,786	
- Domiciliary Care							
- Learning Disability	5,268	-1,532	3,736	480	-67	413	Unit cost above budget level & activity below budget level; additional pressure on extra care housing clients
- Mental Health	532	-114	418	-43	2	-41	
- Older People	44,431	-12,405	32,026	-1,417	1,493	76	Activity for P&V & in-house below budget level; saving on block contracts; income charge higher than budget level
- Physical Disability	7,403	-595	6,808	-94	-62	-156	Activity higher than budget level and unit cost below budget level
Total Domiciliary Care	57,634	-14,646	42,988	-1,074	1,366	292	

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
- Nursing & Residential Care							
- Learning Disability	75,668	-6,456	69,212	173	59	232	Activity above affordable level & Unit cost below budget level for IS; activity below budget level for preserved rights. Delay in review of in-house units
- Mental Health	7,243	-692	6,551	201	-66	135	Unit cost higher than budget level
- Older People - Nursing	46,473	-24,335	22,138	1,794	-960	834	Activity & unit cost above budget level; income charge higher than budget level
- Older People - Residential	84,618	-35,644	48,974	-2,403	1,407	-996	Activity lower than budget level; higher unit cost; in-house staffing pressure; release of contingency; income activity & unit charge lower than budget level
- Physical Disability	13,813	-1,969	11,844	-627	187	-440	Activity lower than budget level; higher unit cost
Total Nursing & Residential Care	227,815	-69,096	158,719	-862	627	-235	
- Supported Accommodation							
- Learning Disability	33,370	-3,645	29,725	-424	728	304	Activity above affordable level & Unit cost below budget level; transfer from reserve; income charge lower than budget
- Physical Disability/Mental Health	2,802	-279	2,523	-90	-141	-231	Income charge higher than budget level
Total Supported Accommodation	36,172	-3,924	32,248	-514	587	73	
- Other Services for Adults & Older People							
- Contributions to Vol Orgs	15,708	-1,793	13,915	111	72	183	Investment in new services
- Day Care							
- Learning Disability	13,187	-237	12,950	-208	52	-156	Staffing savings due to In-house modernisation strategy & reduction in activity; Independent sector saving
- Older People	3,354	-100	3,254	-645	13	-632	re-commissioning strategies
- Physical Disability/Mental Health	1,320	-5	1,315	-80	-2	-82	
Total Day Care	17,861	-342	17,519	-933	63	-870	

Budget Book Heading	Cash Limit			Variance			Comment
	G	I	N	G	I	N	
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	
- Other Adult Services	12,692	-16,990	-4,298	-175	-19	-194	Learning disability development fund staffing & commissioning underspend
- Safeguarding	1,075	-196	879	-46	-8	-54	
Total Other Services for A&OP	47,336	-19,321	28,015	-1,043	108	-935	
- Assessment Services							
- Adult's Social Care Staffing	41,454	-3,940	37,514	-584	132	-452	vacancies: minor income pressures
Community Services:							
- Public Health Management & Support	376	0	376	97	-97	0	
- Public Health	106	-57	49	0	0	0	
Total ASC&PH portfolio	**450,844**	**-113,761**	**337,083**	**-5,589**	**2,892**	**-2,697**	
Business Strategy, Performance & Health Reform portfolio							
- Public Health (LINk, Local Healthwatch & Health Reform)	**758**	**-60**	**698**	**16**	**-16**	0	
Total FSC ADULTS controllable	**451,602**	**-113,821**	**337,781**	**-5,573**	**2,876**	**-2,697**	
Assumed Management Action							
- ASC&PH portfolio						**0**	
- BSP&HR portfolio						**0**	
Forecast after Mgmt Action				**-5,573**	**2,876**	**-2,697**	

1.1.3 **Major Reasons for Variance**: *[provides an explanation of the 'headings' in table 2]*

Table 2, at the end of this section, details all forecast revenue variances over £100k. Each of these variances is explained further below:

Adult Social Care & Public Health portfolio:

From the 1st October, the Supporting Independence Service contract has been introduced and the forecast reported within this monitoring report includes the estimated effect of this contract on all client groups except mental health (where the impact on this service is still being reviewed). The Supporting Independence Service contract is a new purchasing method covering the purchase of community support services, supported accommodation and supported living services. Cash limits have been transferred to reflect the service lines that the current clients have been transferred to, which include a transfer from domiciliary care and supported accommodation to either the supporting independence service (reported within the Supported Accommodation A-Z budget heading) or direct payments (where clients have chosen this option instead, in order to remain with their existing service providers).

1.1.3.1 Strategic Management & Directorate Support Budgets +£346k (+£369K Gross, -£23k Income)
The gross pressure of £369k relates to the estimated pressure from legal charges assuming a similar level of activity as in 2011-12 (+£133k), along with staffing pressures in both Strategic Commissioning Services (+£110k) and the Operational Support Unit (+£125k). Both units were allocated staff savings as part of the 2012-15 MTP, which they hope to achieve via their recent restructures but the full impact of the saving will not be achieved until 2013-14.

1.1.3.2 **Direct Payments -£1,786k (-£1,978k Gross, +£192k Income):**
The significant under spend on this service primarily relates to slower than budgeted increase in activity funded through the 2012-15 MTP. As can be seen from the activity in section 2.1, the number of clients continues to grow at a lower rate than had been budgeted.

a. Learning Disability -£701k (-£973k Gross, +£272k Income)
The forecast underspend against the gross service line of £973k is generated as a result of the forecast activity weeks being 4,211 (-£1,037k) lower than the affordable level, partially offset by the forecast unit cost being higher than the affordable by £1.91 (+£100k). The remaining variance of -£36k relates primarily to under spending on payments to carers.

This service is forecasting an under recovery of income of +£272k, as the actual average unit income being charged is £4.75 lower than the budgeted level resulting in a shortfall of +£248k plus a minor variance due to the reduced level of activity (+£24k).

b. Older People -£632k (-£625k Gross, -£7k Income)
The budget is forecast to under spend by £625k on gross expenditure. The number of weeks is forecast to be 9,242 fewer than budgeted, generating a saving of -£1,337k, which is partially offset by the unit cost being higher than budgeted by £12.83 and therefore generating a pressure of +£674k. The balance of the variance relates to minor pressures on one-off payments and payments to carers (+£38k).

The lower than budgeted number of weeks leads to a shortfall in income of +£170k, however this is more than offset by unit income being £3.37 higher than budgeted resulting in a saving of -£177k.

d. Physical Disability -£457k (-£384k Gross, -£73k income)
The forecast number of weeks of care provided is 3,215 lower than anticipated generating a forecast under spend of -£580k, along with additional savings achieved through a marginally lower than budgeted unit cost (-£22k). These savings are partially offset, predominately by the number of one-off payments being in excess of the budgeted level (+£216k) along with minor pressure on payments to carers (+£2k).

The lower than budgeted number of weeks leads to a shortfall in income of +£28k however this is more than offset by a £1.91 higher than budgeted unit income resulting in a saving of -£101k.

1.1.3.3 **Domiciliary Care +£292k (-£1,074k Gross, +£1,366k Income):**

a. Learning Disability +£413k (+£480k Gross, -£67k Income)
The overall forecast is a pressure against the gross of £480k, coupled with an over recovery of income by £67k. The number of hours is forecast to be 58,869 lower than the affordable level, generating a -£815k forecast under spend. The forecast unit cost is £4.35 higher than the affordable level, increasing the forecast by +£1,051k. The remaining variance of +£244k against gross, is comprised of a pressure on Extra Care Sheltered Housing of +£172k and other minor variances less than £100k each.

The income variance of -£68k reflects an over-recovery of client income of -£420k for community services partly resulting from the re-assessment of clients contributions, partially offset by an under-recovery of income of +£352k within the Independent Living Service due to the placing of fewer clients where income is received from the supporting people service and Health.

b. Older People +£76k (-£1,417k Gross, +£1,493k Income)
The overall forecast is an under spend against gross of -£1,417k, coupled with an under recovery of income of £1,493k. The number of hours is forecast to be 64,487 lower than the affordable hours generating a -£962k forecast under spend. The forecast unit cost is £0.16 higher than the affordable level, partially offsetting this initial forecast underspend by +£380k.

The Kent Enablement at Home (KEAH) in house service is forecasting a gross under spend of -£574k, which is the cumulative effect of less hours of service than budgeted being forecast, and resultant savings in staffing costs. This is in contrast to the purchase of externally provided enablement services where a pressure of +£122k is currently being forecast. A saving of -£356k is also forecast against block domiciliary contracts, as a result of savings on non-care related costs, and where negotiations to have an element of unused hours refunded have been successful, along with a underspend of -£138k for those clients in Sheltered Accommodation.

The remaining gross variance of +£111k relates to the estimated contribution to the bad debt provision resulting from the increase in outstanding client debt this financial year reported in section 3.

The income variance of +£1,493k reflects the under-recovery of client income of +£1,525k which is largely due to the reduced activity, marginally offset by minor variances of -£32k.

d. Physical Disability -£156k (-£94k Gross, -£62k Income)

The gross variance is caused by a forecast of 49,028 hours below the affordable level, creating a -£692k saving, which is offset by a unit cost variance of £1.10 greater than affordable level, causing a pressure of +£571k. The remaining gross pressure (+£27k), and income variance (-£62k) are due to variances on a number of other budgets within this heading, all below £100k.

This forecast is based on actual client activity for the first half year and an assumed reduction for the remainder of the year of approximately 10,000 hours of domiciliary care, based on previous trends.

1.1.3.4 **Nursing & Residential Care -£235k (-£862k Gross, +£627k Income):**

a. Learning Disability +£232k (+£173k Gross, +£59k Income)

A gross pressure of +£173k, coupled with an under recovery of income of £59k generates the above net forecast variance. The forecast level of client weeks is 615 higher than the affordable level generating a +£755k forecast pressure. The gross unit cost is currently forecast to be £3.79 lower than the affordable level, which generates a -£150k forecast under spend. The forecast activity for this service is based on known individual clients including provisional and transitional clients. Provisional clients are those whose personal circumstances are changing and therefore require a more intense care package or greater financial help. Transitional clients are children who are transferring to adult social services.

There are variances on the preserved rights budgets where activity is forecast to be 1,457 weeks lower than affordable creating a saving of -£1,282k offset by a unit cost variance totalling +£646k. In addition, a further saving of -£85k has been generated from a release of a provision no longer required.

There is a +£269k pressure resulting from delays in the review of in-house units and a consequential delay in delivering the budgeted savings. The balance of the gross pressure relates to additional nursing care to be recharged to health (Registered Nursing Care Contribution - RNCC) (+£20k).

The forecast income variance of +£59k is due to a number of compensating variances within residential care. The additional forecast client weeks for residential care add -£55k of income, and the actual income per week is higher than the expected level by £9.74 which generates a further over-recovery in income of -£419k.

The reduction in client weeks compared to the affordable level for preserved rights residential care creates a loss of +£141k of income, coupled with a lower actual income per week than the expected level of £13.27 which generates an under-recovery in income of +£403k.

The remaining income variance of -£11k relates to in house provision and RNCC.

b. Mental Health +£135k (+£201k Gross, -£66k Income)

The forecast gross pressure of £201k is primarily due to the residential care gross unit cost being £19.29 higher than the budgeted level creating a pressure of £199k.

c. Older People - Nursing +£834k (+£1,794k Gross, -£960k Income)

There is a forecast pressure of +£1,794k on gross and an over recovery of income of -£960k, leaving a net pressure of +£834k. The forecast client weeks is 2,254 higher than the affordable level, which generates a pressure of +£1,069k coupled with the unit cost forecast to be £7.93 higher than budget, which gives a gross pressure of +£646k. The remaining gross variance of +£79k relates to additional nursing care to be recharged to health (RNCC) of +£149k partially offset by minor variances on preserved rights and unrealised creditors (-£70k).

The increased activity in nursing care has resulted in a -£456k over-recovery of income, along with an increase in the average unit income being recouped from clients totalling -£390k. Forecast reimbursement from health for RNCC of -£149k along with minor variances on preserved rights (+£35k) form the balance of the income variance.

d. Older People - Residential -£996k (-£2,403k Gross, +£1,407k Income)

This service is reporting a gross under spend of £2,403k, along with an under recovery of income of £1,407k. The forecast level of client weeks is 2,865 lower than the affordable levels, which generates a forecast under spend of -£1,131k. This under spend is partially offset by the unit cost being £1.03 higher than the affordable levels creating a +£155k pressure.

A gross underspend is also forecast for Preserved Rights of -£394k mainly due to a lower than affordable level of activity of 948 weeks creating a -£405k under spend, offset by a +£11k minor pricing pressure.

A gross variance of +£392k is forecast against the In-house provisions, including Integrated Care centres (ICC). The pressure on this service is mainly due to the use of agency staff to cover staff absences and vacancies (+152k), along with costs associated with the integrated care centres which are due to be recharged to the PCT (+£240k, see below for compensating income variance).

Contingency funding was held against this service to help compensate for possible volatility in the forecast for both residential and nursing care because of the impact of the Modernisation agenda. This funding has now been released, resulting in a -£1,345k underspend, to help offset the increases seen in nursing care, as detailed above. The balance of the underspend relates to unrealised creditors totalling -£80k.

On the income side, the reduction in activity results in a +£614k shortfall in client income, along with a lower than budgeted average unit income being charged which has increased this shortfall by +£566k. In addition, there is a forecast under recovery of client income of +£653k for the In-house service, mainly due to less permanent clients being placed in the homes because of the OP Modernisation Strategy, which is partially offset by -£113k additional contributions from other local authorities. The remaining income variance predominately relates to the recharge of costs associated with the integrated care centres to the PCT (-£240k) along with other smaller variances each below £100k (-£73k).

e. Physical Disability -£440k (-£627k Gross, +£187k Income)

A gross under spend of £627k, along with an under recovery of income of £187k, is reported for this budget. The forecast level of client weeks of service is 992 lower than the affordable level, giving a forecast under spend of -£860k. The forecast unit cost is currently £13.58 higher than the affordable level, which reduces that under spend by +£192k. The under spend is further offset by other minor pressures totalling +£41k relating the Preserved Rights service, RNCC clients and unrealised creditors.

The reduced activity is forecast to lower income by +£110k, along other minor pressures totalling +£77k.

1.1.3.5 **Supported Accommodation +£73k (-£514k Gross, +£587k Income):**

a. Learning Disability +£304k (-£424k Gross, +£728k Income)
A gross underspend of -£424k, offset with an under recovery of income of £728k generates the above net variance. The forecast level of client weeks is 830 higher than the affordable level generating a forecast pressure of +£752k. The gross unit cost is currently forecast to be -£20.07 lower than the affordable level, which generates a saving of -£541k. The forecast also includes a expected draw down of -£444k from the Social Care costs reserve for potential liabilities relating to ordinary residence and the remaining gross variances, totalling -£191k are each less than £100k, across other services including group homes, link placements and resource centres.

The increased activity creates a minor over recovery of income (-£52k); however the average unit income is forecast to be +£29.21 lower than budgeted so creating a +£787k under recovery of income. The reduction in unit income is partly due to a reduction in expected income from continuing health care i.e. those clients funded by health. The remaining income variance (-£7k) is on several services under this heading, each below £100k.

b. Physical Disability / Mental Health -£231k (-£90k Gross, -£141k Income)
The is a small over recovery of income of -£141k forecast for both Physical Disability and Mental Health primarily due to a higher than budgeted weekly income per client.

1.1.3.6 **Other Services for Adults & Older People -£935k (-£1,043k Gross, +£108k Income):**

a. Contributions to Voluntary Organisations +£183k (+£111k Gross, +£72k Income)
Various contracts with voluntary organisations are currently being reviewed/re-negotiated or re-commissioned along with investment in new services to support the transformation agenda (including expansion of care navigators programme, a service to explore options with older people to enable them to live independently within their community). The current effect of this is an anticipated pressure of +£111k. The income variance of +£72k is because the profile of payments to voluntary organisations in the current year is more focused on social care rather than health, resulting in reduced contributions from PCTs.

b. Day Care -£870k (-£933k Gross, +£63k Income)
A reduction in staffing levels due to the continued non-recruitment and re-deployment to posts in preparation for modernisation and a reduction in client numbers results in an under spend of -£343k for Learning Disability in-house provision. This is partially offset by a pressure on the commissioning of external learning disability day care services (+£135k). The balance of the gross under spend is mainly due to a number of re-commissioning strategies for in-house and independently provided services across the Older People client group (-£645k) and other minor variances across the other client groups (-£80k). The income pressure of +£63k results from a reduction in health contributions based on the current client profile.

c. Other Adult Services -£194k (-£175k Gross, -£19k Income)
The learning disability development fund is currently forecasting a gross under spend of -£192k due to contracts with organisations being reviewed or renegotiated along with the redeployment of staff following the recent FSC restructure of strategic commissioning and operational support. The balance of the gross variance (+£17k) relates to a number of minor variances on other budget lines.

1.1.3.7 **Assessment Services – Adult's Social Care staffing -£452k (-£584k Gross, +£132k Income):**
The gross underspend of -£584k reflects the current staffing forecast, representing 1.4% of the overall budget for assessment staffing services, and results from the delay in recruitment of known vacancies. The forecast reduction in income of +£132k is due to many minor variances all individually less than £100k.

Table 2: REVENUE VARIANCES OVER £100K IN SIZE ORDER

(shading denotes that a pressure has an offsetting saving, which is directly related, or vice versa)

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
ASCPH	Domiciliary Care - Older People Income: under-recovery of community service income due to reduced activity	+1,525	ASCPH	Residential Care - Older People Gross: release of contigency to help fund pressures on nursing care	-1,345
ASCPH	Nursing Care - Older People Gross: forecast number of weeks higher than affordable level	+1,069	ASCPH	Direct Payments - Older People Gross: forecast number of weeks lower than affordable level	-1,337
ASCPH	Domiciliary Care - Learning Disability Gross: forecast unit cost higher than affordable level	+1,051	ASCPH	Residential Care - Learning Disability Gross: preserved rights number of weeks forecast to be lower than affordable level	-1,282
ASCPH	Supported Accomodation - Learning Disability Income: forecast unit charge lower than affordable level	+787	ASCPH	Residential Care - Older People Gross: forecast number of weeks lower than affordable level	-1,131
ASCPH	Residential Care - Learning Disability Gross: forecast number of weeks greater than affordable level	+755	ASCPH	Direct Payments - Learning Disability Gross: forecast number of weeks lower than affordable level	-1,037
ASCPH	Supported Accomodation - Learning Disability Gross: forecast number of weeks higher than affordable level	+752	ASCPH	Domiciliary Care - Older People Gross: forecast number of hours lower than affordable level	-962
ASCPH	Direct Payments - Older People Gross: forecast unit cost higher than affordable level	+674	ASCPH	Residential Care - Physical Disabiltiy Gross: forecast number of weeks lower than affordable level	-860
ASCPH	Residential Care - Older People Income: lower income resulting from the placing of less permanent clients in in-house units	+653	ASCPH	Domiciliary Care - Learning Disability Gross: forecast number of hours lower than affordable level	-815
ASCPH	Residential Care - Learning Disability Gross: preserved rights unit cost forecast to be higher than affordable level	+646	ASCPH	Domicilary Care - Physical Disability Gross: forecast number of hours lower than affordable level	-692
ASCPH	Nursing Care - Older People Gross: forecast unit cost higher than affordable level	+646	ASCPH	Day Care - Older People Gross: savings from re-commissioning strategies in both in-house & external services	-645
ASCPH	Residential Care - Older People Income: forecast number of weeks lower than affordable level	+614	ASCPH	Assessment Adult's Social Care Staffing Gross: delay in recruitment of known vacancies	-584
ASCPH	Domicilary Care - Physical Disability Gross: forecast unit cost higher than affordable level	+571	ASCPH	Direct Payments - Physical Disability Gross: forecast number of weeks lower than affordable level	-580
ASCPH	Residential Care - Older People Income: forecast unit charge lower than affordable level	+566	ASCPH	Domiciliary Care - Older People Gross: Savings from the Kent Enablement at Home service as a result of forecast activity below budgeted level	-574

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
ASCPH	Residential Care - Learning Disability Income: preserved rights unit charge forecast is lower than affordable level	+403	ASCPH	Supported Accommodation - Learning Disability Gross: forecast unit cost lower than budgeted level	-541
ASCPH	Domiciliary Care - Older People Gross: forecast unit charge higher than affordable level	+380	ASCPH	Nursing Care - Older People Income: forecast number of weeks higher than affordable level	-456
ASCPH	Domiciliary Care - Learning Disability Income: changing client profile in the Independent Living Service leading to reduced levels of support for those clients in receipt of external funding	+352	ASCPH	Supported Accommodation - Learning Disability Gross: expected drawdown from social care costs reserve	-444
ASCPH	Residential Care - Learning Disability Gross: delay in the review of in-house units	+269	ASCPH	Domiciliary Care - Learning Disability Income: over-recovery of community service income compared to budgeted level	-420
ASCPH	Direct Payments - Learning Disability Income: forecast unit charge lower than affordable level	+248	ASCPH	Residential Care - Learning Disability Income: forecast unit charge greater than affordable level	-419
ASCPH	Residential Care - Older People Gross: integrated care centre health costs to be recharged to the PCT	+240	ASCPH	Residential Care - Older People Gross: preserved rights forecast number of weeks lower than affordable level	-405
ASCPH	Direct Payments - Physical Disability Gross: one-off payments in excess of budgeted level	+216	ASCPH	Nursing Care - Older People Income: forecast unit charge higher than affordable level	-390
ASCPH	Residential Care - Mental Health Gross: unit cost forecast to be higher than affordable level	+199	ASCPH	Domiciliary Care - Older People Gross: savings on block contracts	-356
ASCPH	Residential Care - Physical Disabiltiy Gross: forecast unit cost is higher than affordable level	+192	ASCPH	Day Care - Learning Disability Gross: staffing savings on in-house service from modernisation strategy & reduced client numbers	-343
ASCPH	Domiciliary Care - Learning Disability Gross: pressure on Extra Care Sheltered Housing	+172	ASCPH	Residential Care - Older People Income: integrated care centre health costs to be recharged to the PCT	-240
ASCPH	Direct Payments - Older People Income: forecast number of weeks lower than affordable level	+170	ASCPH	Other Adult Services Gross: Learning Disability Development Fund underspend resulting from review of payments to organisations and redeployment of staff	-192
ASCPH	Residential Care - Older People Gross: forecast unit cost higher than affordable level	+155	ASCPH	Direct Payments - Older People Income: forecast unit charge higher than affordable level	-177
ASCPH	Residential Care - Older People Gross: staffing pressure on in-house units due to absences and vacancy cover	+152	ASCPH	Residential Care - Learning Disability Gross: forecast unit cost lower than affordable level	-150
ASCPH	Nursing Care - Older People Gross: additional nursing care to be recharged to health (RNCC)	+149	ASCPH	Nursing Care - Older People Income: additional nursing care to be recharged to health (RNCC)	-149

Pressures (+)			Underspends (-)		
portfolio		£000's	portfolio		£000's
ASCPH	Residential Care - Learning Disability Income: preserved rights number of weeks forecast to be lower than affordable level	+141	ASCPH	Supported Accommodation - Physical Disability/Mental Health Income: forecast unit charge higher than affordable level	-141
ASCPH	Day Care - Learning Disability Gross: pressure on the commissioning of external day care services	+135	ASCPH	Domiciliary Care - Older People Gross: savings on the provision of domi care to clients within sheltered accommodation	-138
ASCPH	Strategic Management & Directorate Support Gross: estimated legal charges pressure based on 11-12 outturn.	+133	ASCPH	Residential Care - Older People Income: additional income received from other local authorities for in-house units	-113
ASCPH	Strategic Management & Directorate Support Gross: staffing pressure on Operational Support Unit.	+125	ASCPH	Direct Payments - Physical Disability Income: forecast unit charge higher than affordable level	-101
ASCPH	Domiciliary Care - Older People Gross: pressure on the provision of enablement services by external providers	+122			
ASCPH	Domicilary Care - Older People Gross: estimated contribution to the bad debt provision to cover rising client debt levels	+111			
ASCPH	Contributions to Voluntary Organisations Gross: review and commissioning of new services to support transformation agenda	+111			
ASCPH	Strategic Management & Directorate Support Gross: staffing pressure on Strategic Commissioning.	+110			
ASCPH	Residential Care - Physical Disabiltiy Income: forecast number of weeks lower than affordable level	+110			
ASCPH	Direct Payments - Learning Disability Gross: forecast unit cost higher than affordable level	+100			
		+14,804			-17,019

1.1.4 **Actions required to achieve this position**:

None

1.1.5 **Implications for MTFP**:

Work is currently underway to establish how the current forecast £2.697m under spend contributes towards the delivery of the transformation programme savings already built into the MTFP.

1.1.6 **Details of re-phasing of revenue projects**:

None

1.1.7 **Details of proposals for residual variance**: *[eg roll forward proposals; mgmt action outstanding]*

Not applicable

1.2 CAPITAL

1.2.1 All changes to cash limits are in accordance with the virement rules contained within the constitution and have received the appropriate approval via the Leader, or relevant delegated authority.

1.2.2 The Adult Social Care and Public Health portfolio has an approved budget for 2012-15 of £88.268m, reduced to £21.468m excluding PFI (see table 1 below). The forecast outturn against this budget is £20.080m, giving a variance of -£1.388m. After adjustments for funded variances and reductions in funding, the revised variance comes to -£1.418m (see table 3 below).

1.2.3 Tables 1 to 3 summaries the portfolio's approved budget and forecast.

1.2.4 Table 1 – Revised approved budget

	£m
Approved budget last reported to Cabinet excl PFI	21.468
Approvals made since last reported to Cabinet	0.000
Revised approved budget	21.468

1.2.5 Table 2 – Funded and Revenue Funded Variances

Scheme	Amount £m	Reason
Cabinet to approve cash limit changes		
Shepway Sports Centre-LD Strategy	0.030	Minor overspend to be covered by dev conts
No cash limit changes to be made		
Total	**0.030**	

1.2.6 Table 3 – Summary of Variance

	£m
Unfunded variance	**0.000**
Funded variance (from table 2)	0.030
Variance to be funded from revenue	0.000
Rephasing (beyond 2012-15)	**-1.418**
Total variance	-1.388

Main reasons for variance

1.2.7 Table 4 below, details each scheme indicating all variances and the status of the scheme. Each scheme with a Red or Amber status will be explained including what is being done to get the scheme back to budget/on time.

Annex 3

Table 4 – Scheme Progress

Scheme name	Total cost	Previous spend	2012-15 approved budget	Later Years approved budget	2012-15 Forecast spend	Later Years Forecast spend	2012-15 Variance	Total project variance	Status Red /amber /green
	£m	£m	£m	£m	£m	£m	£m	£m	
	(a) = b+c+d	(b)	(c)	(d)	(e)	(f)	(g) = (e-c)	(h)=(b+e+f)-a	
Modernisation of Assets (Adults)	0.810	0.437	0.373	0.000	0.373	0.000	0.000	0.000	Green
Home Support Fund	9.456	4.312	3.532	1.612	3.532	1.612	0.000	0.000	Green
Tunbridge Wells Respite (formerly Rusthall Site)	0.217	0.167	0.050	0.000	0.050	0.000	0.000	0.000	Green
Bower Mount Project	0.060	0.048	0.012	0.000	0.007	0.000	-0.005	-0.005	Green
MH Strategy	0.547	0.283	0.264	0.000	0.264	0.000	0.000	0.000	Green
Public Access	1.700	0.516	1.184	0.000	1.184	0.000	0.000	0.000	Green
Bearsted Dementia Project	0.025	0.025	0.000	0.000	0.000	0.000	0.000	0.000	Green
Folkestone Activities, Respite & Rehabilitation Care Centre	0.031	0.001	0.030	0.000	0.030	0.000	0.000	0.000	Green
IT Strategy (Formerly IT Infrastructure Grant - IT Related Projects)	3.121	0.924	2.197	0.000	2.197	0.000	0.000	0.000	Amber - Phasing
Dartford TC - OP Strategy - Trinity Centre, Dartford	1.121	0.122	0.999	0.000	0.999	0.000	0.000	0.000	Green
OP Strategy - Specialist Care Facilities (Formerly Int Care Ctre & Dorothy Lucy Ctre)	5.088	0.000	5.088	0.000	5.088	0.000	0.000	0.000	Green
PFI Excellent Homes for all - Development of new Social Housing	66.800	0.000	66.800	0.000	66.800	0.000	0.000	0.000	Green
LD Modernisation-Good Day Programme	6.749	0.427	6.322	0.000	6.357	0.000	0.035	0.035	Green
Community Care Centre - Thameside Eastern Quarry/Ebbsfleet	1.418	0.000	1.418	0.000	0.000	1.097	-1.418	-0.321	Amber - Phasing
TOTAL Adults Social Care and Public Health	**97.142**	**7.262**	**88.269**	**1.612**	**86.881**	**2.709**	**-1.388**	**-0.291**	

1.2.8 Status:
Green – Projects on time and budget
Amber – Projects either delayed or over budget
Red – Projects both delayed and over budget

1.2.9 Assignment of Green/Amber/Red Status

1.2.10 Projects with variances to budget will only show as amber if the variance is unfunded, i.e. there is no additional grant, external or other funding available to fund.

1.2.11 Projects are deemed to be delayed if the forecast completion date is later than what is in the current project plan.

Amber and Red Projects – variances to cost/delivery date and why.

1.2.12 Even though the projects listed below have no overall variances to cost, they have been deemed Amber as a result of the expected delivery date slipping from what was previously scheduled to happen as part of the medium term plan process.

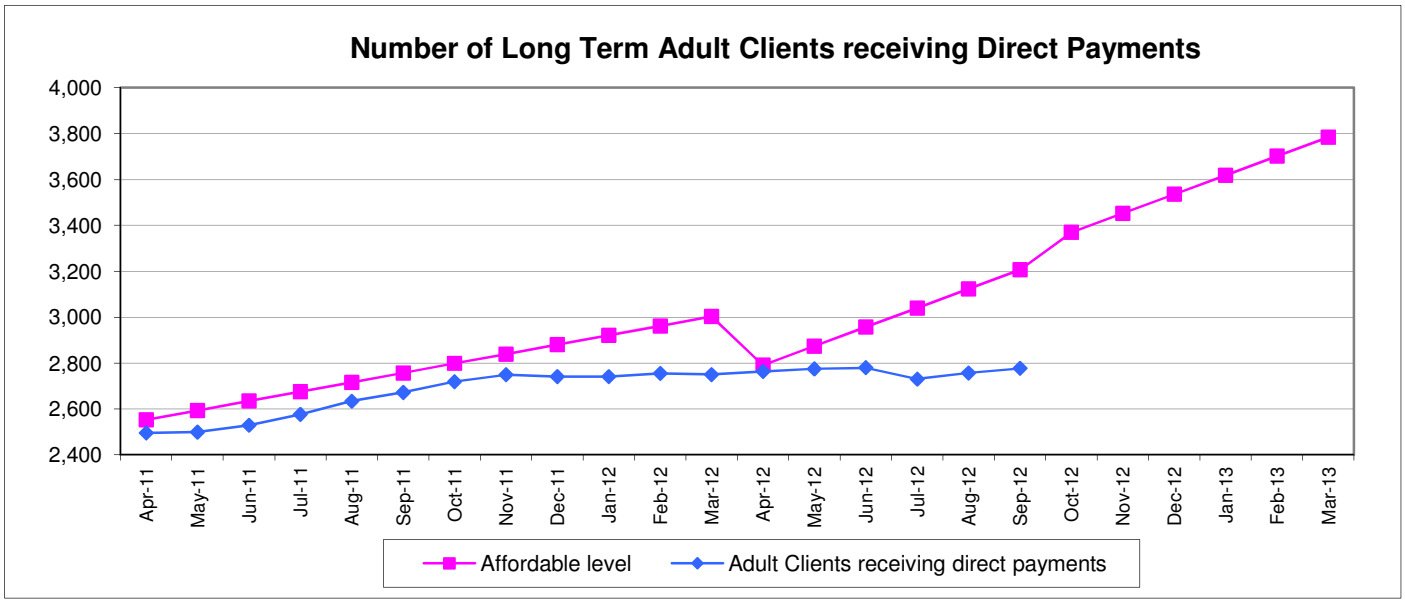
1.2.13 Information Technology Strategy/Modernisation of Assets - As a result of the decision to postpone the implementation of the Adults Integration Solution (AIS) workstream to all localities, pending further conclusive outcomes, coupled with an over-arching strategic review scheduled to be carried out by the Authority's Director of ICT, the Directorate has decided to show prudency and delay elements of this project into 2013/14.

1.2.14 Community Care Centre – Thameside Eastern Quarry/Ebbsfleet - There is re-phasing of £1.418m to 2015/16. This is due to the housing development relating to this project not progressing at the expected rate. There has also been a budget refreshment to the Ebbsfleet project resulting in a reduction of £0.321m to the cash limit in 2015-16.

2. KEY ACTIVITY INDICATORS AND BUDGET RISK ASSESSMENT MONITORING

2.1 Direct Payments – Number of Adult Social Services Clients receiving Direct Payments:

	2011-12			2012-13		
	Affordable Level for long term clients	Snapshot of long term adult clients receiving Direct Payments	Number of one-off payments made during the month	Affordable Level for long term clients	Snapshot of long term adult clients receiving Direct Payments	Number of one-off payments made during the month
April	2,553	2,495	137	2,791	2,759	165
May	2,593	2,499	89	2,874	2,772	145
June	2,635	2,529	90	2,957	2,778	129
July	2,675	2,576	125	3,040	2,728	145
August	2,716	2,634	141	3,123	2,756	149
September	2,757	2,672	126	3,207	2,777	117*
October	2,799	2,719	134	3,370		
November	2,839	2,749	122	3,453		
December	2,881	2,741	111	3,536		
January	2,921	2,741	130	3,619		
February	2,962	2,755	137	3,702		
March	3,003	2,750	117	3,785		
			1,459			**850**



Comments:

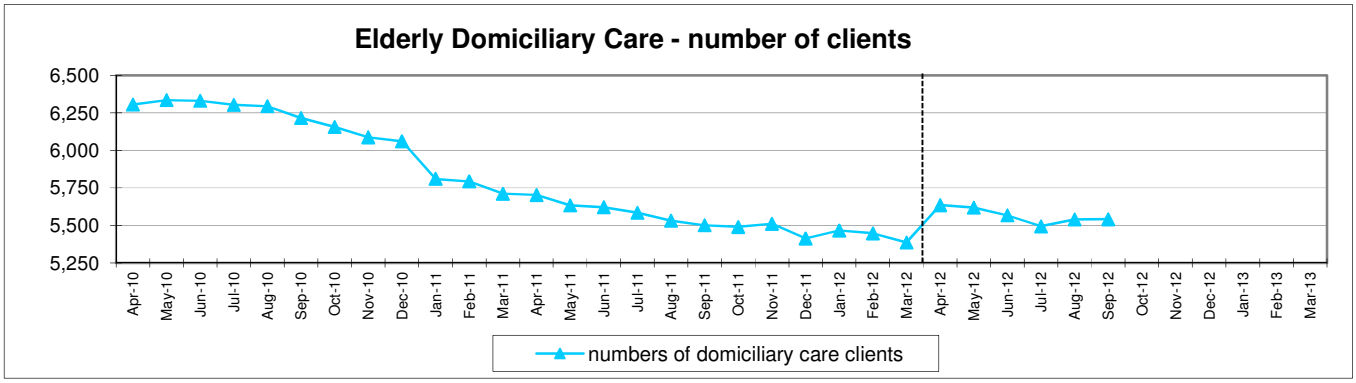
- The presentation of activity being reported for direct payments has changed from previous reports in order to separately identify long term clients in receipt of direct payments as at the end of the month plus the number of one-off payments made during the month. Please note a long term client in receipt of a regular direct payment may also receive a one-off payment if required. Only the long term clients are presented on the graph above.
- *Please note the low number of one-off payments in September may be due to delays in recording payments and will be updated in the quarter 3 full monitoring return to be reported to Cabinet in March.
- The drive to implement personalisation and allocate personal budgets has seen continued increases in direct payments over the years. There will be other means by which people can use their personal budgets and this may impact on the take up of direct payments. Whilst the overall numbers of Direct Payments are gradually increasing this is at a slower rate than the budget can afford, leading to a forecast gross under spend of -£1.978m as shown in section 1.1.3.2. It is important to note, the current forecast is based on known clients only and does not factor in future growth in this service.

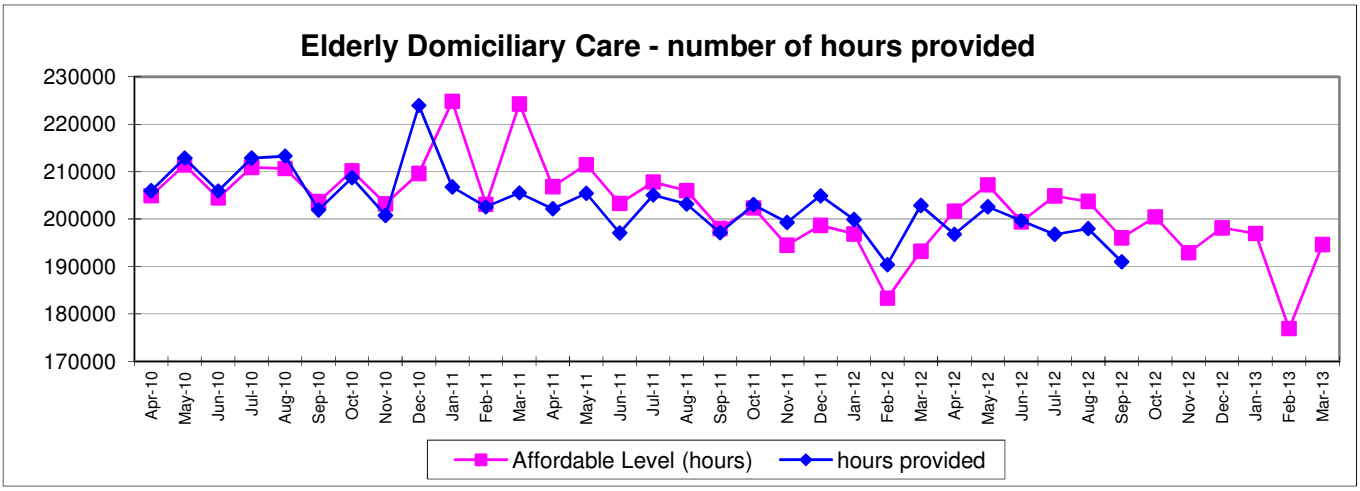
This service received a significant amount of monies in the 2012-13 Budget (£3.5m) for the predicted growth in this service.

- The affordable levels have been corrected to reflect the number of long term clients the budget can afford. The previous affordable levels represented the number of long term clients plus an estimate for the number of one payments to be made during the year. This was incorrect as there is no budget for one-off payments as these are expected to be covered by the recovery of surplus funds from existing direct payment clients and therefore any pressures resulting from one-off payments are detailed separately within section 1.1.3.2 of the report.

2.2.1 Elderly domiciliary care – numbers of clients and hours provided in the independent sector

	2010-11			2011-12			2012-13		
	Affordable level (hours)	hours provided	number of clients	Affordable level (hours)	hours provided	number of clients	Affordable level (hours)	hours provided	number of clients
April	204,948	205,989	6,305	206,859	202,177	5,703	201,708	196,796	5,635
May	211,437	212,877	6,335	211,484	205,436	5,634	207,244	202,594	5,619
June	204,452	205,937	6,331	203,326	197,085	5,622	199,445	199,657	5,567
July	210,924	212,866	6,303	207,832	205,077	5,584	204,905	196,791	5,494
August	210,668	213,294	6,294	206,007	203,173	5,532	203,736	197,994	5,540
September	203,708	201,951	6,216	198,025	197,127	5,501	196,050	190,996	5,541
October	210,155	208,735	6,156	202,356	203,055	5,490	200,490		
November	203,212	200,789	6,087	194,492	199,297	5,511	192,910		
December	209,643	223,961	6,061	198,704	204,915	5,413	198,151		
January	224,841	206,772	5,810	196,879	199,897	5,466	196,982		
February	203,103	202,568	5,794	183,330	190,394	5,447	176,918		
March	224,285	205,535	5,711	193,222	202,889	5,386	194,644		
TOTAL	**2,521,376**	**2,501,274**		**2,402,516**	**2,410,522**		**2,373,183**	**1,184,828**	





Comment:

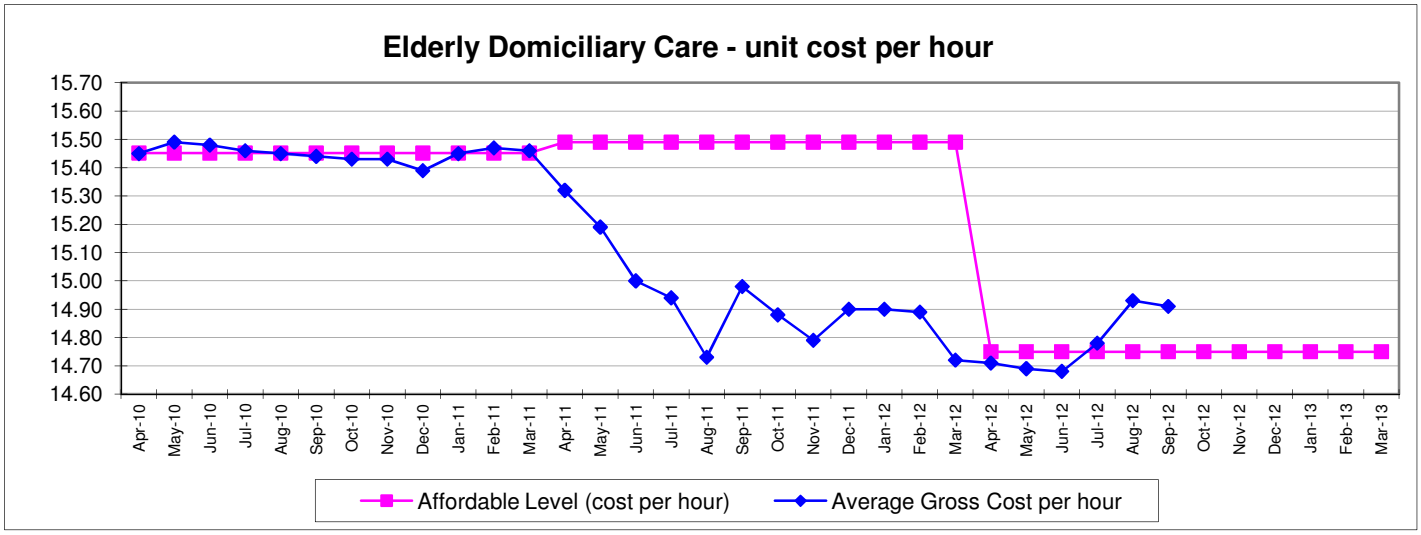
- Figures exclude services commissioned from the Kent Enablement At Home Service.
- The current forecast is 2,308,699 hours of care against an affordable level of 2,373,183, a difference of -64,487 hours. Using the forecast unit cost of £14.91 this reduction in activity reduces the forecast by -£962k, as highlighted in section 1.1.3.3.b.
- To the end of September 1,184,828 hours of care have been delivered against an affordable level of 1,213,088 a difference of -28,260 hours. Current activity suggests that the forecast hours should be higher on this service, however further reductions in the number of hours provided have been forecast for the remainder of the year as the forecast is based on actual client activity for the first half year and

an assumed reduction for the remainder of the year of approximately 13,000 hours of domiciliary care, based on the budgeted unit cost, to deliver outstanding MTP domiciliary procurement savings of £198k.

- Please note, from April 2012 there has been a change in the method of counting clients to align with current Department of Health guidance, which states that suspended clients e.g those who may be in hospital and not receiving a current service should still be counted. This has resulted in an increase in the number of clients being recorded. For comparison purposes, using the new counting methodology, the equivalent number of clients in March 2012 would have been 5,641**. A dotted line has been added to the graph to distinguish between the two different counting methodologies, as the data presented is not on a consistent basis and therefore is not directly comparable**.
- Domiciliary for all client groups are volatile budgets, with the number of people receiving domiciliary care decreasing over the past few years as a result of the implementation of Self Directed Support (SDS). This is being compounded by a shift in trend towards take up of the enablement service.
- Please note the affordable level of client hours has been updated from 2,368,339 included in the Q1 monitoring report to Cabinet in September to 2,373,183 to reflect the allocation of health monies for domiciliary care and the transfer of clients to the new Supporting Independence Service, as explained in section 1.1.3.

2.2.2 **Average gross cost per hour of older people domiciliary care compared with affordable level**:

	2010-11		2011-12		2012-13	
	Affordable Level (Cost per Hour)	Average Gross Cost per Hour	Affordable Level (Cost per Hour)	Average Gross Cost per Hour	Affordable Level (Cost per Hour)	Average Gross Cost per Hour
April	15.452	15.45	15.49	15.32	14.75	14.71
May	15.452	15.49	15.49	15.19	14.75	14.69
June	15.452	15.48	15.49	15.00	14.75	14.68
July	15.452	15.46	15.49	14.94	14.75	14.78
August	15.452	15.45	15.49	14.73	14.75	14.93
September	15.452	15.44	15.49	14.98	14.75	14.91
October	15.452	15.43	15.49	14.88	14.75	
November	15.452	15.43	15.49	14.79	14.75	
December	15.452	15.39	15.49	14.90	14.75	
January	15.452	15.45	15.49	14.90	14.75	
February	15.452	15.47	15.49	14.89	14.75	
March	15.452	15.46	15.49	14.72	14.75	



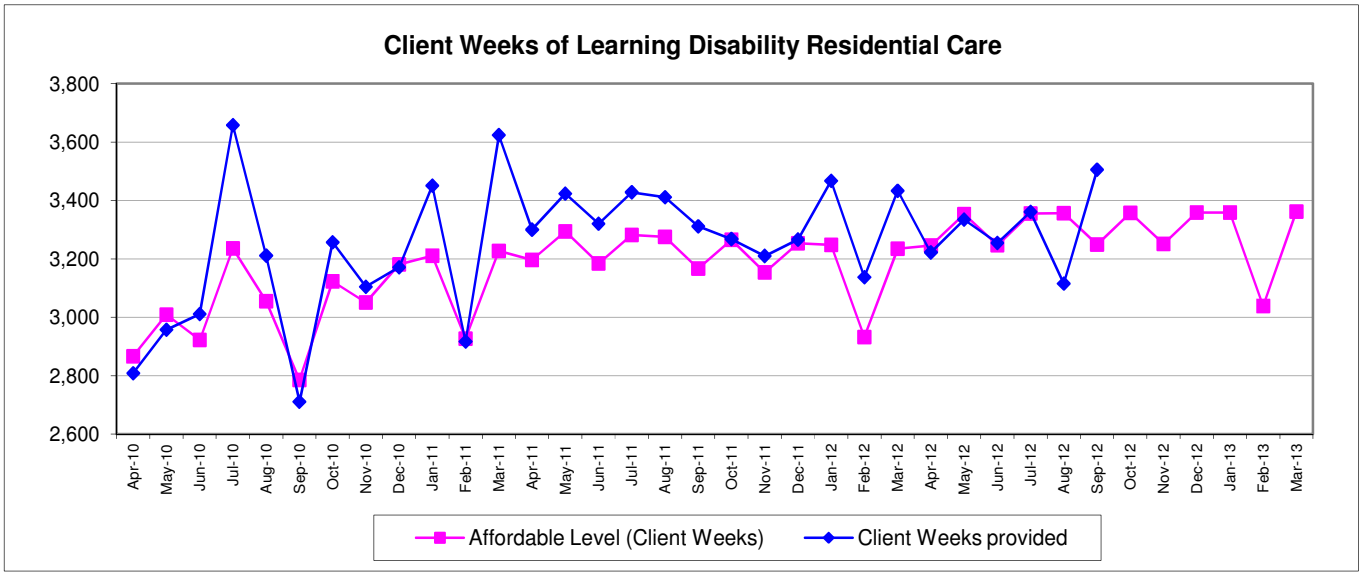
Comments:

- The unit cost has been showing an overall general reducing trend due to current work with providers to achieve savings however, the cost is also dependent on the intensity of the packages required.

- The forecast unit cost of £14.91 is higher than the affordable cost of £14.75 and this difference of +£0.16 increases the forecast by £380k when multiplied by the affordable hours, as highlighted in section 1.1.3.3.b.

2.3.1 **Number of client weeks of learning disability residential care provided compared with affordable level (non preserved rights clients):**

	2010-11		2011-12		2012-13	
	Affordable Level (Client Weeks)	**Client Weeks of LD residential care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD residential care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD residential care provided**
April	2,866	2,808	3,196	3,300	3,246	3,222
May	3,009	2,957	3,294	3,423	3,353	3,334
June	2,922	3,011	3,184	3,320	3,247	3,254
July	3,236	3,658	3,282	3,428	3,355	3,361
August	3,055	3,211	3,275	3,411	3,356	3,115
September	2,785	2,711	3,167	3,311	3,249	3,505
October	3,123	3,257	3,265	3,268	3,357	
November	3,051	3,104	3,154	3,210	3,251	
December	3,181	3,171	3,253	3,266	3,359	
January	3,211	3,451	3,248	3,467	3,359	
February	2,927	2,917	2,932	3,137	3,039	
March	3,227	3,624	3,235	3,433	3,362	
TOTAL	**36,593**	**37,880**	**38,485**	**39,974**	**39,533**	**19,791**

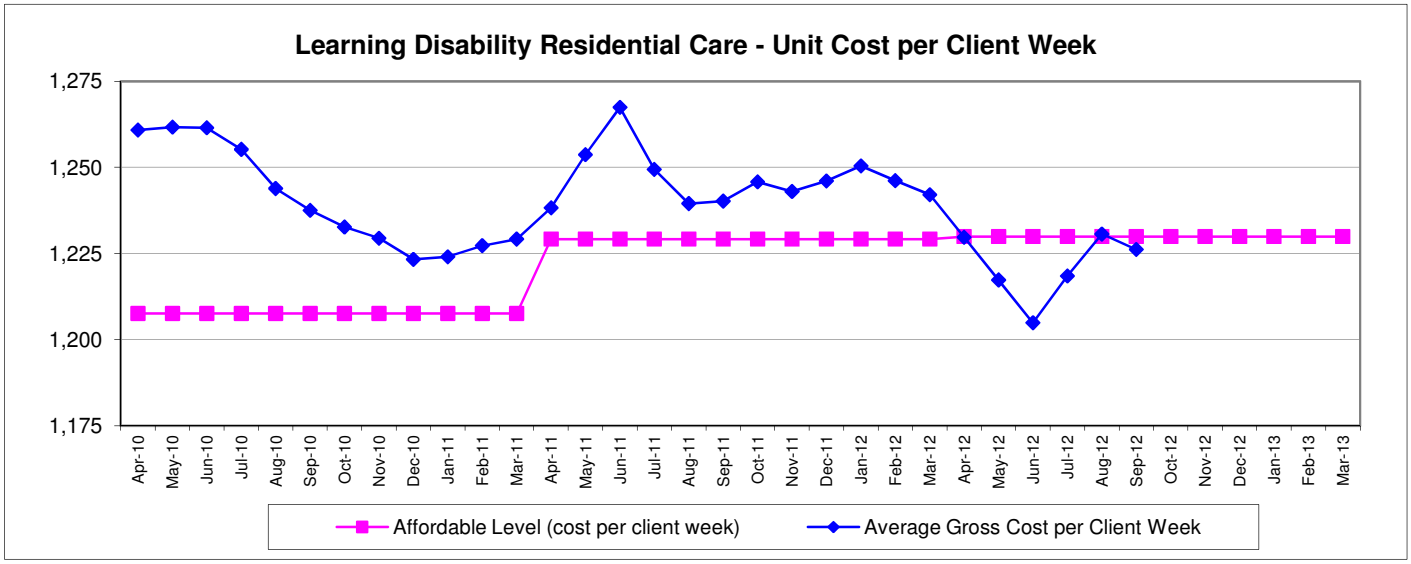


Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in LD residential care at the end of 2010-11 was 713, at the end of 2011-12 it was 746 and at the end of September 2012 it was 750. This includes any ongoing transfers as part of the S256 agreement with Health, transitions, provisions and Ordinary Residence.
- The current forecast is 40,148 weeks of care against an affordable level of 39,533, a difference of +615 weeks. Using the forecast unit cost of £1,226.14 this additional activity adds £755k to the forecast, as highlighted in section 1.1.3.4.a.
- To the end of September 19,791 weeks of care have been delivered against an affordable level of 19,806, a difference of -15 weeks. The current year to date activity suggests only a minor variance however the forecast also includes 358 additional weeks of transition and provision clients (as described in section 1.1.3.4.a) i.e. clients expected to transfer to this service during this financial year and the forecast also includes approximately 300 weeks of non-permanent care services for the remainder of the year.

2.3.2 **Average gross cost per client week of learning disability residential care compared with affordable level (non preserved rights clients)**:

	2010-11		2011-12		2012-13	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	1,207.58	1,260.82	1,229.19	1,238.24	1,229.93	1,229.69
May	1,207.58	1,261.67	1,229.19	1,253.68	1,229.93	1,217.30
June	1,207.58	1,261.46	1,229.19	1,267.40	1,229.93	1,204.91
July	1,207.58	1,255.21	1,229.19	1,249.41	1,229.93	1,218.46
August	1,207.58	1,243.87	1,229.19	1,239.50	1,229.93	1,230.65
September	1,207.58	1,237.49	1,229.19	1,240.17	1,229.93	1,226.14
October	1,207.58	1,232.68	1,229.19	1,245.76	1,229.93	
November	1,207.58	1,229.44	1,229.19	1,242.97	1,229.93	
December	1,207.58	1,223.31	1,229.19	1,246.05	1,229.93	
January	1,207.58	1,224.03	1,229.19	1,250.44	1,229.93	
February	1,207.58	1,227.26	1,229.19	1,246.11	1,229.93	
March	1,207.58	1,229.19	1,229.19	1,242.08	1,229.93	

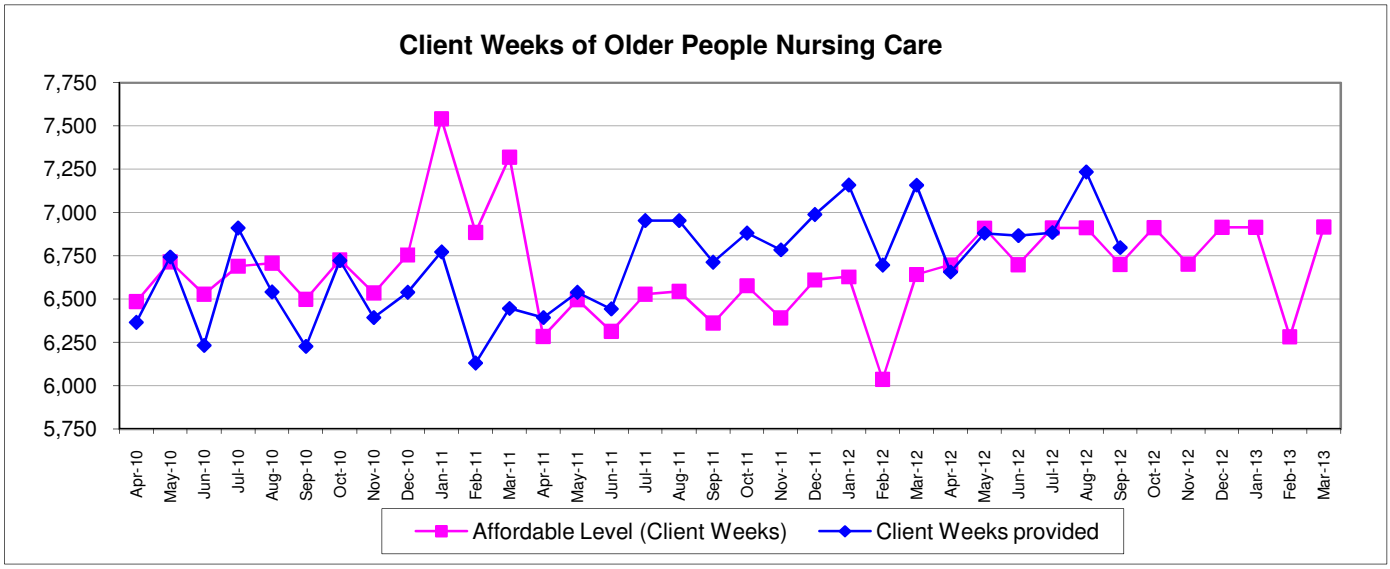


Comments:

- Clients being placed in residential care are those with very complex and individual needs which makes it difficult for them to remain in the community, in supported accommodation/supporting living arrangements, or receiving a domiciliary care package. These are therefore placements which attract a very high cost, with the average now being over £1,200 per week. It is expected that clients with less complex needs, and therefore less cost, can transfer from residential into supported living arrangements. This would mean that the average cost per week would increase over time as the remaining clients in residential care would be those with very high cost – some of whom can cost up to £2,000 per week. In addition, no two placements are alike – the needs of people with learning disabilities are unique and consequently, it is common for average unit costs to increase or decrease significantly on the basis of one or two cases. The general increase in the average cost per week due to the complexity of clients has been offset this financial year by the price savings forecast to be achieved as part of the 2012-13 budget.
- The forecast unit cost of £1,226.14 is higher/lower than the affordable cost of £1,229.93 and this difference of -£3.79 adds/saves £150k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.4.a.
- The rise in the forecast unit cost between June and September reflects the current assumption that the service will not be able to make all of the budgeted procurement savings, with a shortfall of approx. £370k currently anticipated.

2.4.1 **Number of client weeks of older people nursing care provided compared with affordable level:**

	2010-11		2011-12		2012-13	
	Affordable Level (Client Weeks)	**Client Weeks of older people nursing care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of older people nursing care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of older people nursing care provided**
April	6,485	6,365	6,283	6,393	6,698	6,656
May	6,715	6,743	6,495	6,538	6,909	6,880
June	6,527	6,231	6,313	6,442	6,699	6,867
July	6,689	6,911	6,527	6,953	6,911	6,884
August	6,708	6,541	6,544	6,954	6,912	7,235
September	6,497	6,225	6,361	6,713	6,701	6,797
October	6,726	6,722	6,576	6,881	6,913	
November	6,535	6,393	6,391	6,784	6,703	
December	6,755	6,539	6,610	6,988	6,915	
January	7,541	6,772	6,628	7,159	6,915	
February	6,885	6,129	6,036	6,696	6,281	
March	7,319	6,445	6,641	7,158	6,917	
TOTAL	**81,382**	**78,016**	**77,405**	**81,659**	**81,474**	**41,319**



Comment:

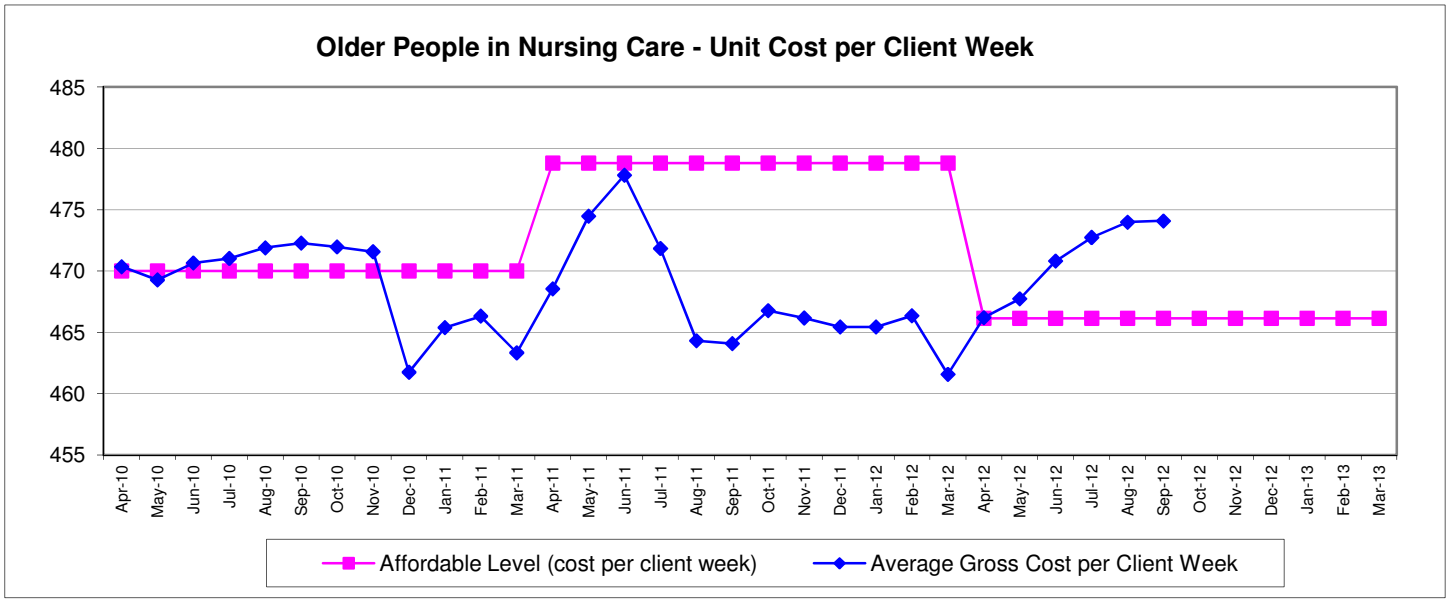
- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people nursing care at the end of 2010-11 was 1,379, at the end of 2011-12 it was 1,479 and at the end of September 2012 it was 1,514.

- The current forecast is 83,728 weeks of care against an affordable level of 81,474, a difference of +2,254 weeks. Using the actual unit cost of £474.09, this additional activity adds +£1,069k to the forecast, as highlighted in section 1.1.3.4.c.

- To the end of September 41,319 weeks of care have been delivered against an affordable level of 40,830, a difference of +489 weeks, Current year to date activity suggests the forecast should be lower for this service however, the number of clients receiving nursing care has increased since the start of the financial year and the full year effect of these clients is forecast throughout the remainder of the financial year plus those in receipt of non-permanent care services.

2.4.2 **Average gross cost per client week of older people nursing care compared with affordable level**:

	2010-11		2011-12		2012-13	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	470.01	470.36	478.80	468.54	466.16	466.20
May	470.01	469.27	478.80	474.48	466.16	467.74
June	470.01	470.67	478.80	477.82	466.16	470.82
July	470.01	471.03	478.80	471.84	466.16	472.74
August	470.01	471.90	478.80	464.32	466.16	473.99
September	470.01	472.28	478.80	464.09	466.16	474.09
October	470.01	471.97	478.80	466.78	466.16	
November	470.01	471.58	478.80	466.17	466.16	
December	470.01	461.75	478.80	465.44	466.16	
January	470.01	465.40	478.80	465.44	466.16	
February	470.01	466.32	478.80	466.36	466.16	
March	470.01	463.34	478.80	461.58	466.16	



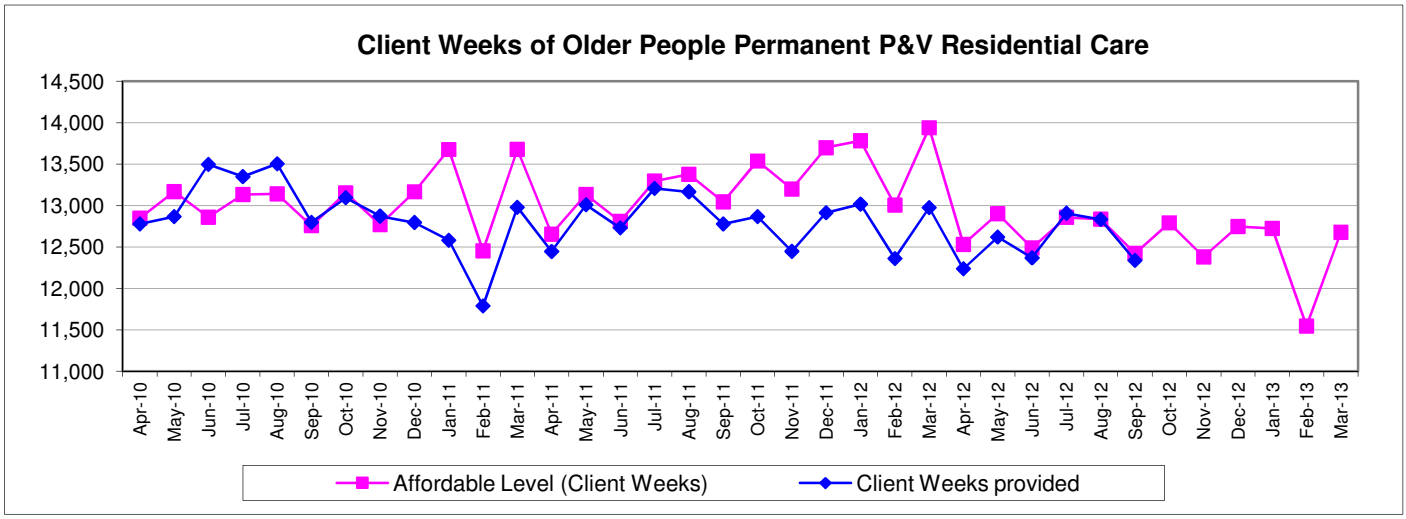
Comments:

- As with residential care, the unit cost for nursing care will be affected by the increasing proportion of older people with dementia who need more specialist and expensive care, which is why the unit cost can be quite volatile and in recent months this service has seen an increase of older people requiring this more specialist care.

- The forecast unit cost of £474.09 is higher than the affordable cost of £466.16 and this difference of +£7.93 adds £646k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.4.c.

2.5.1 **Number of client weeks of older people permanent P&V residential care provided compared with affordable level**:

	2010-11		2011-12		2012-13	
	Affordable Level (Client Weeks)	**Client Weeks of older people permanent P&V residential care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of older people permanent P&V residential care provided**	**Affordable Level (Client Weeks)**	**Client Weeks of older people permanent P&V residential care provided**
April	12,848	12,778	12,655	12,446	12,532	12,237
May	13,168	12,867	13,136	13,009	12,903	12,621
June	12,860	13,497	12,811	12,731	12,489	12,369
July	13,135	13,349	13,297	13,208	12,858	12,908
August	13,141	13,505	13,377	13,167	12,836	12,832
September	12,758	12,799	13,044	12,779	12,424	12,339
October	13,154	13,094	13,538	12,868	12,792	
November	12,771	12,873	13,200	12,448	12,382	
December	13,167	12,796	13,700	12,914	12,748	
January	13,677	12,581	13,782	13,019	12,726	
February	12,455	11,790	13,007	12,361	11,545	
March	13,678	12,980	13,940	12,975	12,679	
TOTAL	**156,812**	**154,909**	**159,487**	**153,925**	**150,914**	**75,306**

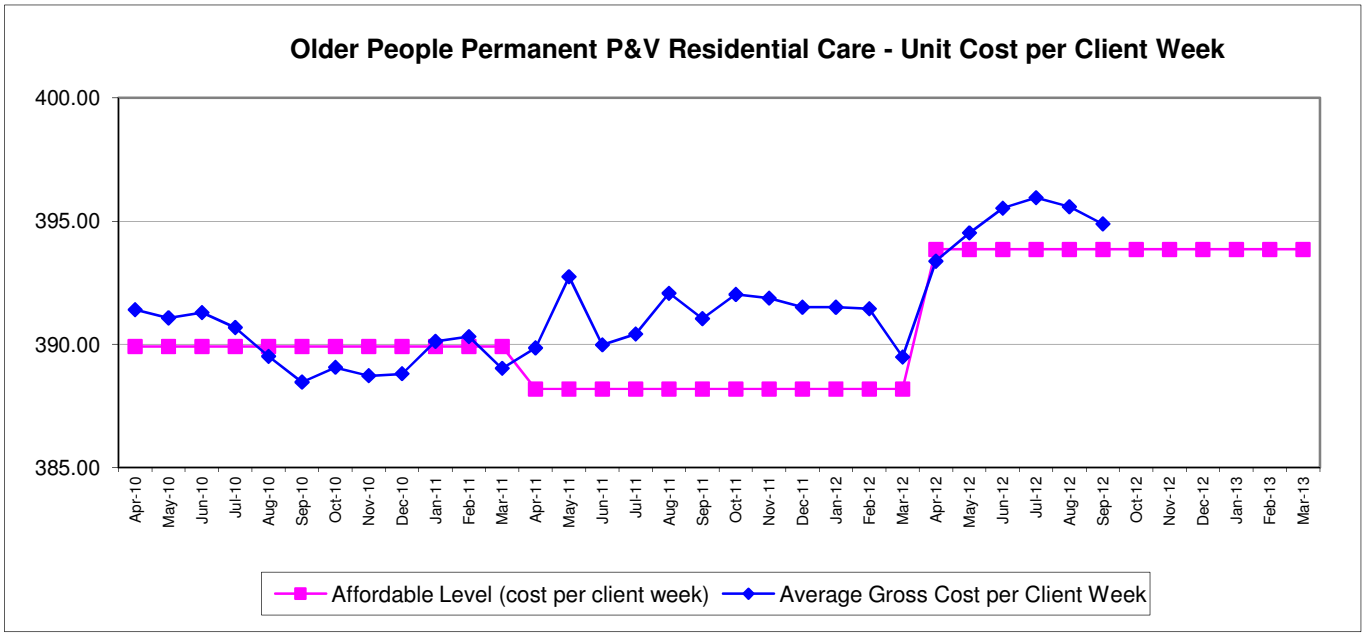


Comments:

- The above graph reflects the number of client weeks of service provided as this has a greater influence on cost than the actual number of clients. The actual number of clients in older people permanent P&V residential care at the end of 2010-11 it was 2,787, at the end of 2011-12 it was 2,736 and by the end of September 2012 it was 2,726. It is evident that there are ongoing pressures relating to clients with dementia who require a greater intensity of care.
- It is difficult to consider this budget line in isolation, as the Older Person's modernisation strategy has meant that fewer people are being placed in our in-house provision, so we would expect that there will be a higher proportion of permanent placements being made in the independent sector which is masking the extent of the overall reducing trend in residential client activity.
- The current forecast is 148,049 weeks of care against an affordable level of 150,914, a difference of -2,865 weeks. Using the forecast unit cost of £394.88 this reduced activity saves -£1,131k from the forecast, as highlighted in section 1.1.3.4.d.
- To the end of September 75,306 weeks of care have been delivered against an affordable level of 76,042, a difference of -736 weeks. The current year to date activity suggests the forecast should be higher, however the number of clients receiving residential care is expected to continue to reduce in the later part of the year, therefore the forecast number of weeks reflects this further anticipated reduction in client numbers during the remainder of the financial year.

2.5.2 **Average gross cost per client week of older people permanent P&V residential care compared with affordable level**:

	2010-11		2011-12		2012-13	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	389.91	391.40	388.18	389.85	393.85	393.37
May	389.91	391.07	388.18	392.74	393.85	394.52
June	389.91	391.29	388.18	389.97	393.85	395.52
July	389.91	390.68	388.18	390.41	393.85	395.95
August	389.91	389.51	388.18	392.07	393.85	395.58
September	389.91	388.46	388.18	391.04	393.85	394.88
October	389.91	389.06	388.18	392.02	393.85	
November	389.91	388.72	388.18	391.87	393.85	
December	389.91	388.80	388.18	391.50	393.85	
January	389.91	390.12	388.18	391.50	393.85	
February	389.91	390.31	388.18	391.44	393.85	
March	389.91	389.02	388.18	389.48	393.85	

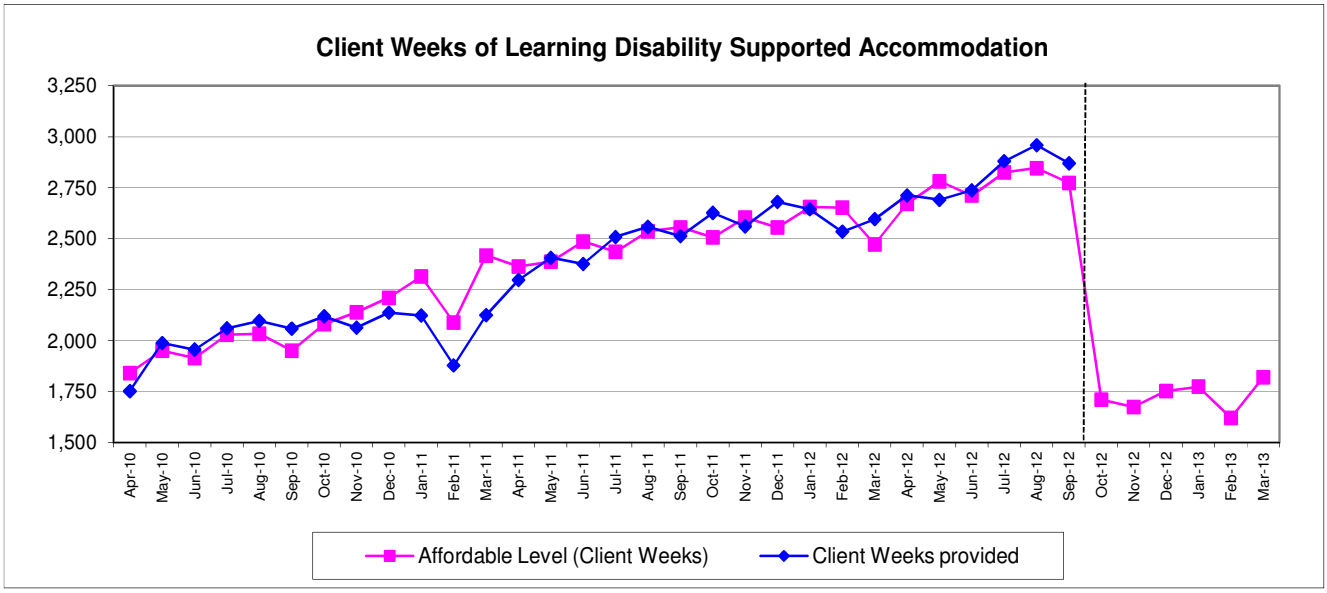


Comments:

- The forecast unit cost of £394.88 is higher than the affordable cost of £393.85 and this difference of +£1.03 adds +£155k to the position when multiplied by the affordable weeks, as highlighted in section 1.1.3.4.d. This higher average unit cost is likely to be due to the higher proportion of clients with dementia, who are more costly due to the increased intensity of care required, as outlined above.

2.6.1 **Number of client weeks of learning disability supported accommodation provided compared with affordable level:**

	2010-11		2011-12		2012-13	
	Affordable Level (Client Weeks)	**Client Weeks of LD supported accommodation provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD supported accommodation provided**	**Affordable Level (Client Weeks)**	**Client Weeks of LD supported accommodation provided**
April	1,841	1,752	2,363	2,297	2,670	2,712
May	1,951	1,988	2,387	2,406	2,781	2,690
June	1,914	1,956	2,486	2,376	2,711	2,737
July	2,029	2,060	2,435	2,508	2,824	2,879
August	2,034	2,096	2,536	2,557	2,845	2,958
September	1,951	2,059	2,555	2,512	2,773	2,869
October	2,080	2,119	2,506	2,626	1,710	
November	2,138	2,063	2,603	2,560	1,675	
December	2,210	2,137	2,554	2,680	1,753	
January	2,314	2,123	2,655	2,644	1,774	
February	2,088	1,878	2,652	2,534	1,621	
March	2,417	2,125	2,472	2,595	1,820	
TOTAL	**24,967**	**24,356**	**30,204**	**30,295**	**26,957**	**16,845**



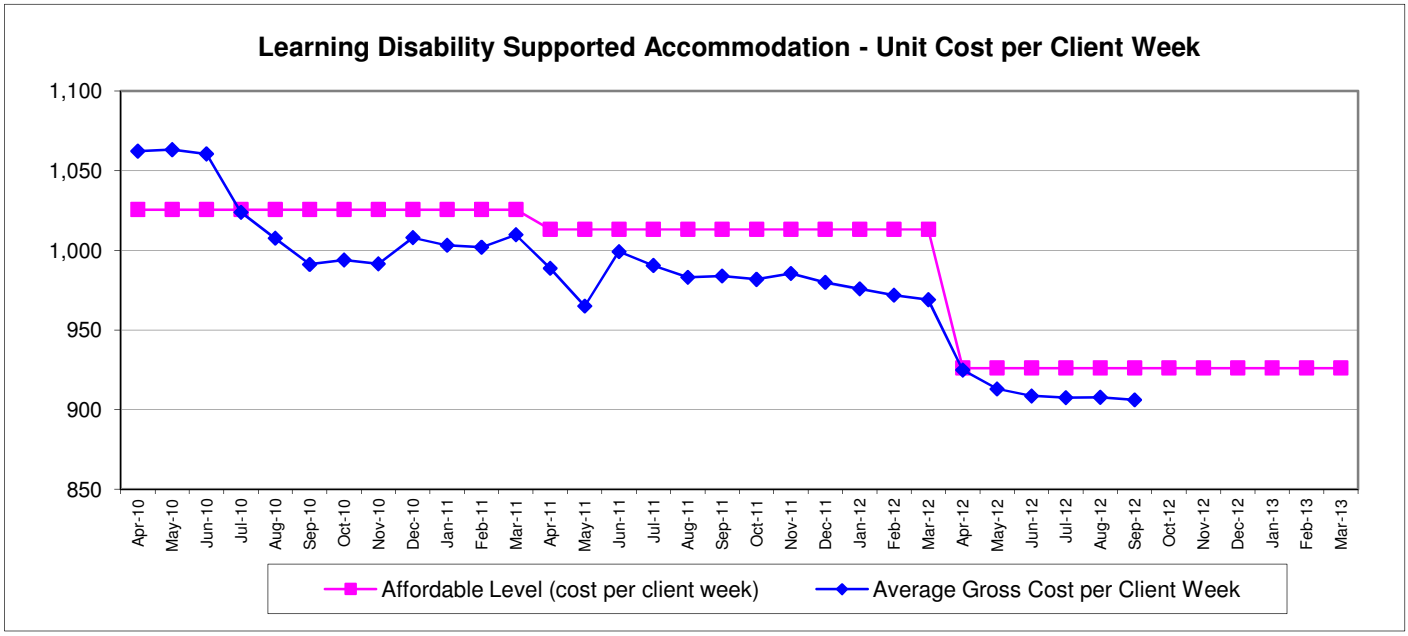
Comments:

- The affordable level for 2012-13 has been amended for this quarter because from 1st October 2012 the Supporting Independence Service is being introduced and as a result a significant number of clients currently receiving supported accommodation services will be transferring to this new arrangement and will no longer be forecast under this activity indicator. This is represented by the significant drop in budgeted level from October 2012 onwards. The Supporting Independence Service clients will be reported separately within the Supported Accommodation A-Z budget and are not recorded as part of the activity above. We will be reviewing the way we report supported accommodation for next year to see whether it is possible to combine both services within a single measure. **A dotted line has been added to the graph to illustrate the introduction of the new Supporting Independence Service, and the consequent transfer of clients from Supported Accommodation, as the data presented either side of the dotted line is not on a consistent basis and is therefore not directly comparable.**

- The above graph reflects the number of client weeks of service provided. The actual number of clients in LD supported accommodation at the end of 2010-11 was 491 of which 131 were S256 clients, at the end of 2011-12 it was 607 of which 156 were S256 clients, and at the end of September 2012 it was 650 (of which 104 are S256).
- The current forecast is 27,787 weeks of care against an affordable level of 26,957, a difference of +830 weeks. Using the forecast unit cost of £906.09 this increase in activity provides a pressure of +£752k, as reflected in section 1.1.3.5.a.
- To the end of September 16,845 weeks of care have been delivered against an affordable level of 16,604, a difference of +241 weeks. Current year to date activity suggests the forecast should be lower for this service however, the forecast includes approximately 650 weeks of expected transition and provision clients above the budgeted level, therefore there is expected to be an increased pressure on this service in the coming months.
- Like residential care for people with a learning disability, every case is unique and varies in cost, depending on the individual circumstances. Although the quality of life will be better for these people, it is not always significantly cheaper. The focus to enable as many people as possible to move from residential care into supported accommodation means that more and increasingly complex and unique cases will be successfully supported to live independently.

2.6.2 **Average gross cost per client week of learning disability supported accommodation compared with affordable level (non preserved rights clients)**:

	2010-11		2011-12		2012-13	
	Affordable Level (Cost per Week)	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**	**Affordable Level (Cost per Week)**	**Average Gross Cost per Client Week**
April	1,025.67	1,062.38	1,013.18	988.73	926.16	924.87
May	1,025.67	1,063.22	1,013.18	964.95	926.16	912.93
June	1,025.67	1,060.59	1,013.18	999.24	926.16	908.53
July	1,025.67	1,023.90	1,013.18	990.45	926.16	907.44
August	1,025.67	1,007.58	1,013.18	983.09	926.16	907.63
September	1,025.67	991.20	1,013.18	983.85	926.16	906.09
October	1,025.67	993.92	1,013.18	981.78	926.16	
November	1,025.67	991.56	1,013.18	985.45	926.16	
December	1,025.67	1,007.95	1,013.18	979.83	926.16	
January	1,025.67	1,003.21	1,013.18	975.90	926.16	
February	1,025.67	1,001.98	1,013.18	971.85	926.16	
March	1,025.67	1,009.82	1,013.18	969.09	926.16	



Comments:

- The forecast unit cost of £906.09 is lower than the affordable cost of £926.16 and this difference of -£20.07 provides a saving of -£541k when multiplied by the affordable weeks. The forecast unit cost assumes £290k of the £854k procurement saving is still to be achieved before the end of the financial year.
- There are three distinct groups of clients: Section 256 clients, Ordinary Residence clients and other clients. Each group has a very different unit cost, which are combined to provide an average unit cost for the purposes of this report.
- The costs associated with these placements will vary depending on the complexity of each case and the type of support required in each placement. This varies enormously between a domiciliary type support to life skills and daily living support.
- Please note, from 2012-13 the unit cost has been recalculated to exclude spend associated with better homes active lives accommodation as these clients are not included in the client weeks reported in section 2.6.1 above. For comparison the revised March 2012 unit cost would have been £936.81 per client per week. In addition, the budgeted unit cost has been further lowered to reflect the procurement savings in the 2012-15 MTP.

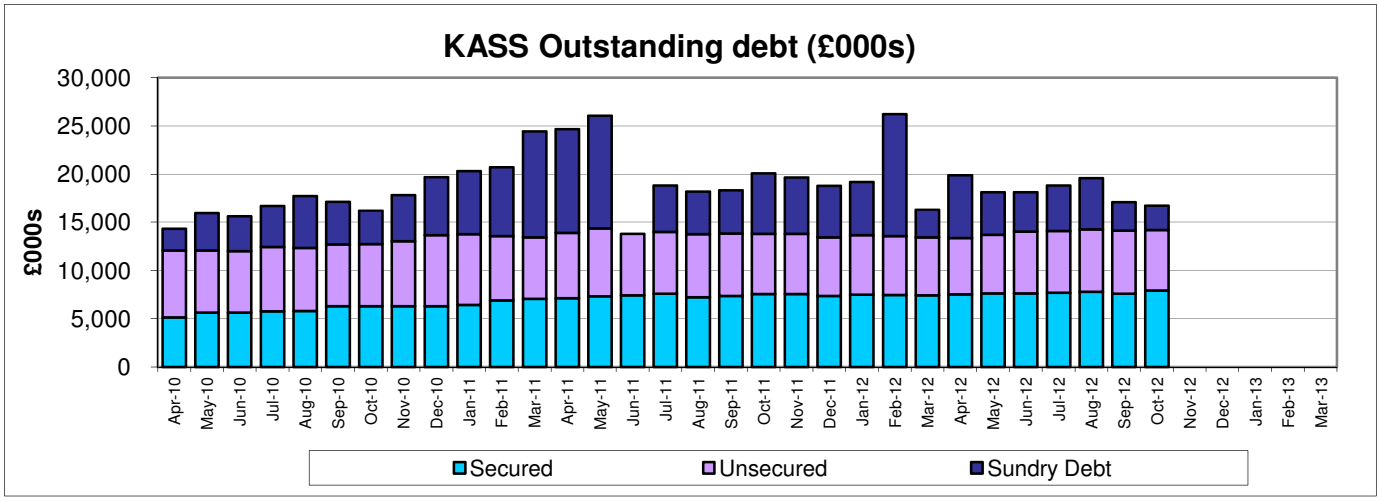
3. SOCIAL CARE DEBT MONITORING

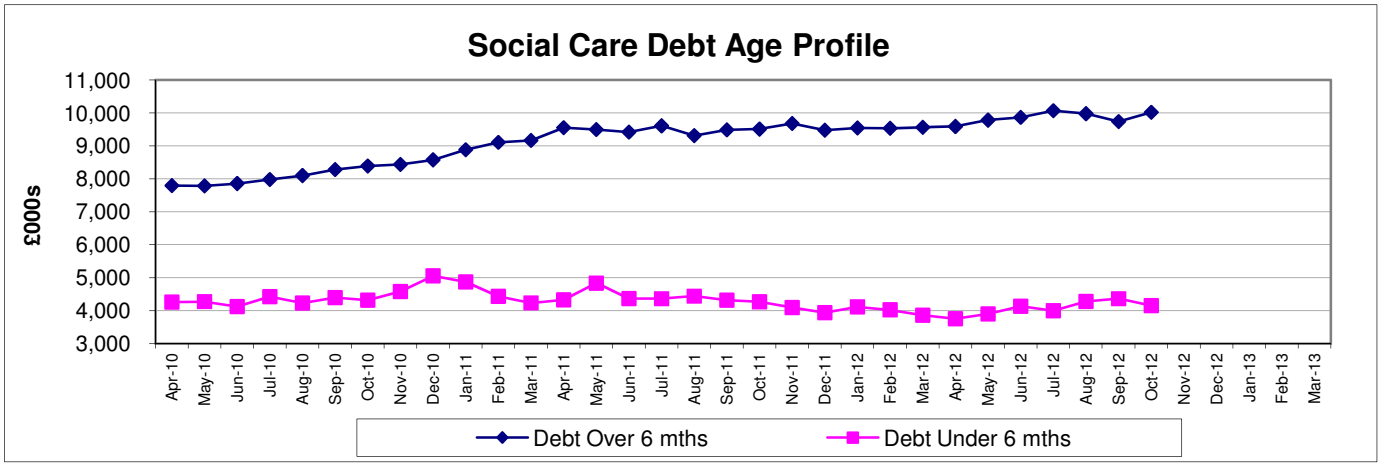
The outstanding debt as at the end of October was £16.747m compared with July's figure of £18.816m (reported to Cabinet in September) excluding any amounts not yet due for payment (as they are still within the 28 day payment term allowed). Within this figure is £2.574m of sundry debt compared to £4.750m in July. The amount of sundry debt can fluctuate for large invoices to health. Also within the outstanding debt is £14.173m relating to Social Care (client) debt which is a small increase of £0.107m from the last reported position to Cabinet in September. The following table shows how this breaks down in terms of age and also whether it is secured (i.e. by a legal charge on the client's property) or unsecured, together with how this month compares with previous months. For most months the debt figures refer to when the four weekly invoice billing run interfaces with Oracle (the accounting system) rather than the calendar month, as this provides a more meaningful position for Social Care Client Debt. This therefore means that there are 13 billing invoice runs during the year. The sundry debt figures are based on calendar months.

			Social Care Debt				
Debt Month	**Total Due Debt (Social Care & Sundry Debt) £000s**	**Sundry Debt £000s**	**Total Social Care Due Debt £000s**	**Debt Over 6 mths £000s**	**Debt Under 6 mths £000s**	**Secured £000s**	**Unsecured £000s**
Apr-10	**14,294**	**2,243**	12,051	7,794	4,257	5,132	6,919
May-10	**15,930**	**3,873**	12,057	7,784	4,273	5,619	6,438
Jun-10	**15,600**	**3,621**	11,979	7,858	4,121	5,611	6,368
Jul-10	**16,689**	**4,285**	12,404	7,982	4,422	5,752	6,652
Aug-10	**17,734**	**5,400**	12,334	8,101	4,233	5,785	6,549
Sep-10	**17,128**	**4,450**	12,678	8,284	4,394	6,289	6,389
Oct-10	**16,200**	**3,489**	12,711	8,392	4,319	6,290	6,421
Nov-10	**17,828**	**4,813**	13,015	8,438	4,577	6,273	6,742
Dec-10	**19,694**	**6,063**	13,631	8,577	5,054	6,285	7,346
Jan-11	**20,313**	**6,560**	13,753	8,883	4,870	6,410	7,343
Feb-11	**20,716**	**7,179**	13,537	9,107	4,430	6,879	6,658
Mar-11	**24,413**	**11,011**	13,402	9,168	4,234	7,045	6,357
Apr-11	**24,659**	**10,776**	13,883	9,556	4,327	7,124	6,759
May-11	**26,069**	**11,737**	14,332	9,496	4,836	7,309	7,023
Jun-11	**13,780**	*	13,780	9,418	4,362	7,399	6,381
Jul-11	**18,829**	**4,860**	13,969	9,608	4,361	7,584	6,385
Aug-11	**18,201**	**4,448**	13,753	9,315	4,438	7,222	6,531
Sep-11	**18,332**	**4,527**	13,805	9,486	4,319	7,338	6,467
Oct-11	**20,078**	**6,304**	13,774	9,510	4,264	7,533	6,241
Nov-11	**19,656**	**5,886**	13,770	9,681	4,089	7,555	6,215
Dec-11	**18,788**	**5,380**	13,408	9,473	3,935	7,345	6,063
Jan-12	**19,180**	**5,518**	13,662	9,545	4,117	7,477	6,185
Feb-12	**26,218**	**12,661**	13,557	9,536	4,021	7,455	6,102
Mar-12	**16,310**	**2,881**	13,429	9,567	3,862	7,411	6,018
Apr-12	**19,875**	**6,530**	13,345	9,588	3,757	7,509	5,836
May-12	**18,128**	**4,445**	13,683	9,782	3,901	7,615	6,068
Jun-12	**18,132**	**4,133**	13,999	9,865	4,134	7,615	6,384
Jul-12	**18,816**	**4,750**	14,066	10,066	4,000	7,674	6,392
Aug-12	**19,574**	**5,321**	14,253	9,977	4,276	7,762	6,491
Sep-12	**17,101**	**3,002**	14,099	9,738	4,361	7,593	6,506
Oct-12	**16,747**	**2,574**	14,173	10,020	4,153	7,893	6,280
Nov-12	**0**		0				
Dec-12	**0**		0				
Jan-13	**0**		0				
Feb-13	**0**		0				
Mar-13	**0**		0				

***** It should be noted that the Sundry debt reports were not successful in June 2011, and hence no figure can be reported, the problem was rectified in time for the July report, but reports are unable to be run retrospectively.

In addition the previously reported secured and unsecured debt figures for April 2012 to July 2012 have been amended slightly following a reassessment of some old debts between secured and unsecured.





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From: Graham Gibbens, Cabinet Member for Adult Social Care & Public Health
Jenny Whittle, Cabinet Member for Specialist Children's services
Andrew Ireland, Corporate Director for Families and Social Care

To: Social Care and Public Health Cabinet Committee – 11 January 2013

Subject: Families and Social Care Performance Dashboard for October 2012

Classification: Unrestricted

Summary: The draft Families & Social Care performance dashboard provides members with progress against targets set for key performance and activity indicators for 2012-13.

Recommendation: Members are asked to REVIEW the Families & Social Care performance dashboard.

Introduction

1. Appendix 2 Part 4 of the Kent County Council Constitution states that:

   "Cabinet Committees shall review the performance of the functions of the Council that fall within the remit of the Cabinet Committee in relation to its policy objectives, performance targets and the customer experience."

2. To this end, each Cabinet Committee is receiving a performance dashboard.

Performance Report

3. There are two main elements of the Report which members are asked to consider:

   - The Children's Social Care dashboard report found at **Appendix A**
   - The Adult's Social Care dashboard report found at **Appendix B.**

4. In particular members are asked to note that both dashboards are used within the Directorate. The children's dashboard is used to support the Improvement Board, and the adult's dashboard is in a transition phase, and will be amended in line with the priorities and objectives of the transformation programme in the next few months.

5. A subset of these indicators is used within the quarterly performance report, which is submitted to Cabinet.

6. As an outcome of this report, members may make reports and recommendations to the Leader, Cabinet Members, the Cabinet or officers.

Performance dashboard

7. The draft Families and Social Care performance dashboards includes latest available results for the key performance and activity indicators.

8. The indicators included are based on key priorities for the Directorate, as outlined in the business plans, and include operational data that is regularly used within Directorate. The dashboard may evolve for Adults Social Care as the transformation programme is shaped. Cabinet Committees have a role to review the selection of indicators included in dashboards, improving the focus on strategic issues and qualitative outcomes, and this will be a key element for reviewing the dashboard.

9. Where frequent data is available for indicators the results in the dashboard are shown either with the latest available month (in most cases May) and a year to date figure, or where appropriate as a rolling 12 month figure.

10. Performance results are assigned an alert on the following basis:

    Green: Current target achieved or exceeded

    Red: Performance is below a pre-defined minimum standard

    Amber: Performance is below current target but above minimum standard.

11. It should be noted that for some indicators where improvement is expected to be delivered steadily over the course of the year, this has been reflected in phased targets. Year End Targets are shown in the dashboards but full details of the phasing of targets can be found in the Cabinet approved business plans.

Recommendations

12. Members are asked to:
    REVIEW the Families & Social Care performance dashboards

Contact Information

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Background documents: none

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Scorecard - Kent, inc UASC

Oct 2012

ID	Indicators	Polarity	Data Period	LATEST RESULT: Latest Result and RAG Status		LATEST RESULT: Num	LATEST RESULT: Denom	LATEST RESULT: Target for 12/13	PREVIOUS RESULT: Previous Reported Result	PREVIOUS RESULT: DoT from previous to latest result	OUTTURN RESULT: Outturn (March 12) Result	OUTTURN RESULT: DoT from outturn to latest result
	HOW MUCH ARE WE DEALING WITH ?											
A1	Number of CAFs completed per 10,000 population under 18	T	R12M	62.9	R	1965	312597	77.2	60.7	↑	68.5	↓
A2	Number of Referrals per 10,000 population under 18	T	R12M	396.7	R	12400	312597	543.7	376.2	↑	538.4	↓
A3	NI 68 - Percentage of Referrals going on to Initial Assessment	T	YTD	81.0%	R	5749	7096	69.5%	85.8%	↑	89.8%	↑
A4	Number of Initial Assessments per 10,000 population under 18	T	R12M	348.7	G	10900	312597	342.9	349.9	↑	483.6	↑
A5	Number of New & Updated Core Assessments per 10,000 population under 18	T	R12M	341.3	R	10668	312597	236.0	342.2	↑	456.0	↑
A6	Number of S47 Investigations per 10,000 population under 18	T	R12M	126.3	R	3947	312597	106.4	132.1	↑	202.7	↑
A7	Percentage of S47 Investigations proceeding to Initial CP Conference	T	YTD	36.5%	R	675	1849	44.5%	33.9%	↑	21.7%	↑
A8	Number of Initial CP Conferences per 10,000 population under 18	T	R12M	37.3	A	1166	312597	42.3	37.1	↑	54.3	↑
A9	Number of CIN per 10,000 population under 18 (includes CP and LAC)	T	SS	289.7	G	9055	312597	280.0	282.3	↓	296.4	↑
A10	Numbers of Children with a CP Plan per 10,000 population under 18	T	SS	27.1	A	847	312597	30.5	25.7	↑	30.6	↓
A11	Children looked after per 10,000 population aged under 18 (Excludes Asylum)	T	SS	51.8	G	1619	312597	47.5	51.8	↓	51.7	↓
A12	Number of Looked After Children with a CP plan.	L	SS	35	A			30	40	↑	36	↑
A13	Numbers of Unallocated Cases for over 28 days (Business)	L	SS	0	G			0	0	→	8	↑
	HOW LONG IS IT TAKING US ?											
B1	NI 59 - Percentage of IA's that were carried out within 7 working days of referral	H	YTD	87.5%	G	5033	5749	78.8%	88.1%	↓	76.2%	↑
B2	Initial Assessments in progress outside of timescale	L	SS	63	G			100	37	↓	42	↓
B3	(NI 60) - Percentage of Core Assessments that were carried out within timescale	H	YTD	83.1%	A	4785	5761	83.2%	83.8%	↓	68.7%	↑
B4	Core Assessments in progress outside of timescale	L	SS	78	G			100	75	↓	84	↑
B5	NI 67 - Child protection cases which were reviewed within required timescales	H	YTD	99.3%	G	551	555	98.0%	98.5%	↑	97.1%	↑
B6	NI 66 - Looked after children cases which were reviewed within required timescales	H	YTD	96.5%	A	1626	1685	98.0%	96.4%	↑	94.9%	↑
	HOW WELL ARE WE DOING IT ?											
C1	Percentage of Case File Audits judged adequate or better	H	YTD	71.3%	R	402	564	85.0%	72.2%	↓	64.1%	↑
C2	Percentage of open cases with Ethnicity recorded (excludes unborn)	H	SS	99.2%	G	8820	8893	98.0%	98.9%	↑	97.4%	↑
C3	Percentage of Children seen at Initial Assessment (excludes unborn/progress to strat)	H	YTD	90.5%	A	3913	4322	95.0%	90.4%	↑	61.6%	↑
C4	Percentage of Children seen at Core Assessment (excludes unborn)	H	YTD	97.9%	G	5357	5474	95.0%	97.9%	↓	88.0%	↑
C5	Percentage of Children seen at Section 47 enquiry (excludes unborn)	H	YTD	97.4%	G	1690	1736	95.0%	97.1%	↑	91.3%	↑
C6	Percentage of CP Visits held within timescale (Current CP only)	H	SS	84.6%	A	9771	11551	90.0%	83.2%	↑	65.8%	↑
C7	Percentage of Looked After Children aged 5 to 16 with a Personal Education Plan (PEP)	H	SS	89.0%	A	966	1086	95.0%	88.1%	↑	81.8%	↑
C8	Participation at Looked After Children Reviews	H	YTD	97.0%	G	2289	2361	95.0%	97.2%	↓	94.1%	↑
C9	Children subject to a CP Plan not allocated to a Qualified Social Worker	L	SS	0	G			0	0	→	2	↑
C10	Looked After Children not allocated to a Qualified Social Worker	L	SS	1	R			0	7	↑	2	↑

Scorecard - Kent, inc UASC

Oct 2012

ID	Indicators	Polarity	Data Period	LATEST RESULT: Latest Result and RAG Status		LATEST RESULT: Num	LATEST RESULT: Denom	Target for 12/13	PREVIOUS RESULT: Previous Reported Result	PREVIOUS RESULT: DoT from previous to latest result	OUTTURN RESULT: Outturn (March 12) Result	OUTTURN RESULT: DoT from outturn to latest result
	ARE WE ACHIEVING GOOD OUTCOMES ?											
D1	Percentage of referrals with a previous referral within 12 months	L	YTD	23.1%	G	1637	7096	25.8%	23.1%	↑	30.4%	↑
D2	NI 65 - Percentage of children becoming CP for a second or subsequent time	T	YTD	22.5%	R	135	601	13.4%	26.0%	↑	16.6%	↓
D13	Percentage of children becoming CP for a second or subequent time within 12 months		YTD	8.2%		49	601		10.4%			
D3	NI 64 - Child Protection Plans lasting 2 years or more at the point of de-registration	L	YTD	7.3%	R	52	708	6.0%	7.7%	↑	8.0%	↑
D4	Percentage of Current CP Plans lasting 18 months or more	L	SS	14.0%	A	119	847	10.0%	14.0%	↓	14.2%	↑
D5	NI 62 - LAC Placement Stability: 3 or more placements in the last 12 months	L	SS	9.4%	R	172	1826	8.1%	9.8%	↑	11.1%	↑
D6	NI 63 - LAC Placement Stability: Same placement for last 2 years	H	SS	72.6%	A	332	457	75.7%	72.2%	↑	70.3%	↑
D7	Percentage of LAC in Foster Care placed within 10 miles from home (Excludes Asylum)	H	SS	61.4%	A	740	1205	65.0%	61.7%	↓	60.6%	↑
D8	LAC Dental Checks held within required timescale	H	SS	88.1%	A	1263	1434	90.0%	86.0%	↑	92.6%	↓
D9	LAC Health assessments held within required timescale	H	SS	92.2%	G	1322	1434	90.0%	89.1%	↑	88.1%	↑
D10	Percentage of LAC placed for adoption within 12 months of agency decision	H	YTD	69.9%	R	51	73	85.0%	72.1%	↓	76.6%	↓
D11	Percentage of Children leaving care who were adopted	H	YTD	11.1%	R	57	512	13.0%	10.4%	↑	8.3%	↑
D12	Percentage of Children leaving care who were made subject to a SGO	H	YTD	5.5%	A	28	512	6.3%	5.9%	↓	4.8%	↑
	ARE WE SUPPORTING OUR STAFF ?											
E1	Percentage of caseholding posts unfilled (100% - QSW inc Agency Posts)	L	SS	-2.2%	G			10%	-2.9%	↓	-0.8%	↑
E2	Percentage of caseholding posts filled by agency staff (Agency Staff ÷ Establishment)	L	SS	13.8%	A	64.8	469.4	10%	15.2%	↑	13.9%	↑
E3	Percentage of caseholding posts filled by QSW (QSW posts exc Agency ÷ Establishment)	H	SS	88.4%	A	415.0	469.4	90%	87.7%	↑	87.0%	↑
E4	Average Caseloads of social workers in fieldwork teams	L	SS	17.6	G	479.8	8459	20	18	↑	20.6	↑

PERFORMANCE SUMMARY

As at 31/10/2012, Kent has 17 indicators rated as Green, 15 indicators rated as Amber and 13 indicators rated as Red. When comparing performance from last month to this month, 29 indicators have shown an improvement, 2 indicators have remained the same and 14 indicators have shown a reduction. When comparing performance from outturn (March 12) to this month, 37 indicators have shown an improvement, 0 indicators have remained the same and 8 indicators have shown a reduction.

Adult Social Care Dashboard

October 2012

Key to RAG (Red/Amber/Green) ratings applied to KPIs

GREEN	Target has been achieved or exceeded
AMBER	Performance is behind target but within acceptable limits
RED	Performance is significantly behind target and is below an acceptable pre-defined minimum *
↑	Performance has improved relative to targets set
↓	Performance has worsened relative to targets set

* In future, when annual business plan targets are set, we will also publish the minimum acceptable level of performance for each indicator which will cause the KPI to be assessed as Red when performance falls below this threshold.

Adult Social Care Indicators
The key Adult Social Care indicators are listed in summary form below, with more detail in the following pages. A subset of these indicators feed into the Quarterly Monitoring Report, for Cabinet, and a subset of these indicators feed into the Bold Steps Monitoring. This is clearly labelled on the summary and in the detail.

Some indicators are monthly indicators, some are annual, and this is clearly stated.

All information is as at may 2012 where possible, with a few indicators still requiring some update, with new targets and indicators being chosen.

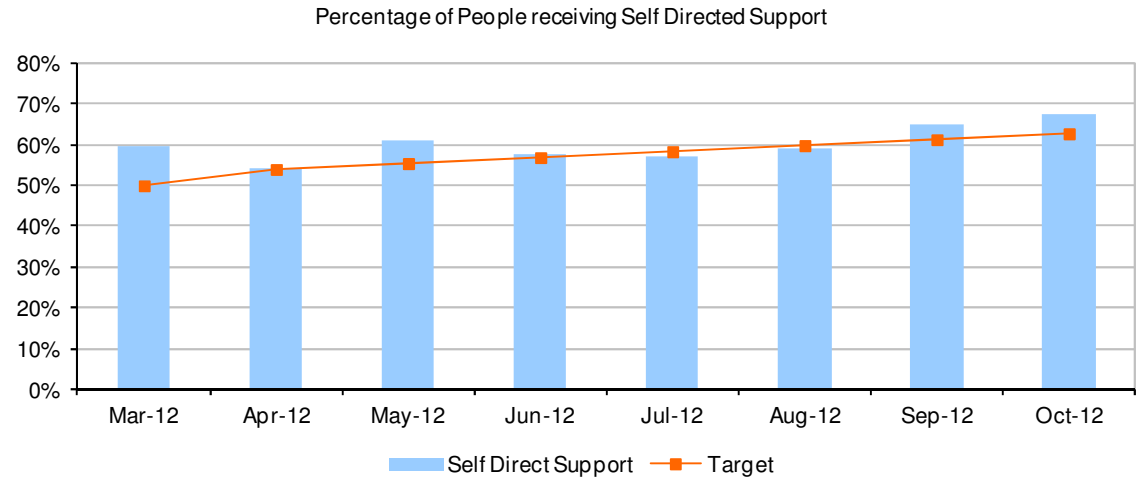
Following months will provide all information.

Summary of Performance for our KPIs

Indicator Description	Bold Steps	QPR	2011-12 Out-turn	2012-13 Target	Current Position	Data Period	RAG	Direction of Travel
1. Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment	Y	Y	59%	70%	**67.2%**	12M	GREEN	↑
2. Proportion of personal budgets given as a direct payment	Y		24.13%	25%	**20.3%**	12M		↑
3. Number of adult social care clients receiving a telecare service	Y	Y	1032	1300	**1321**	Cumulative	GREEN	↑
4. Number of adult social care clients provided with an enablement service	Y	Y	612	700	**605**	Month	AMBER	↑
5. Percentage of adult social care assessments completed within six weeks		Y	76.68%	75%	**78.4%**	12M	GREEN	↑
6. Percentage of clients satisfied that desired outcomes have been achieved at their first review		Y	73.6%	75%	**73.6%**	Month	AMBER	↓
7. Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			85.9%	85%	**81.7%**	Month	AMBER	↑
8. Delayed Transfers of Care	Y		5.04	5.40	**5.35**	12M	GREEN	↑
9. Admissions to Permanent Residential Care for Older People			164	145	**151**	12M	AMBER	↓
10. People with Learning Disabilities in residential care	Y		1288	1260	**1277**	Month	AMBER	↓
11. Proportion of adults in contact with secondary Mental Health in settled accommodation	Y		62.0%	75%	**84.5%**	Quarterly	GREEN	↓

Indicator Description	Bold Steps	QPR	2011-12 Out-turn	2012-13 Target	Current Position	Data Period	RAG	Direction of Travel
1. Percentage of adult social care clients with community based services who receive a personal budget and/or a direct payment								**GREEN ⇧**

Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



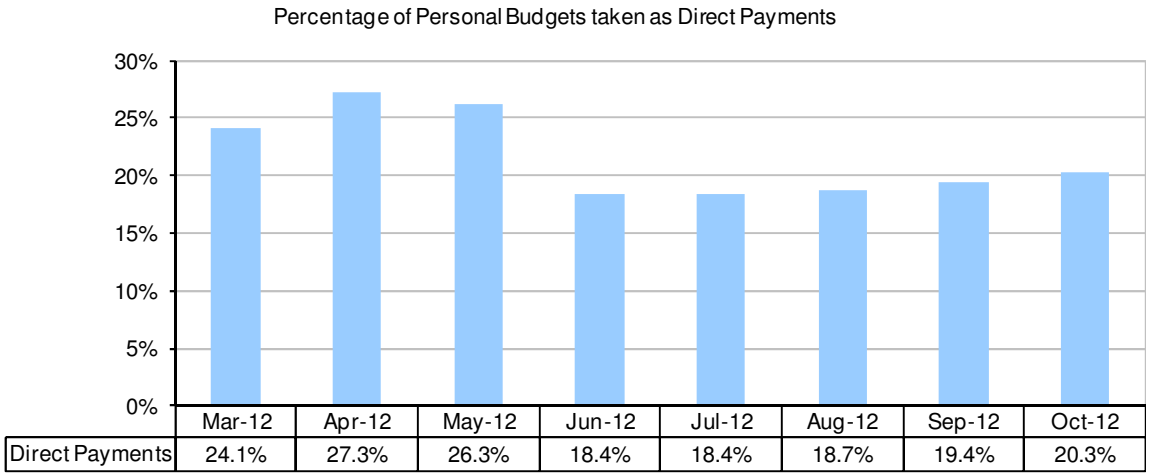
Data Notes.
Units of Measure: Percentage of people with an open service who have a Personal Budget or Direct Payment
Data Source: Adult Social Care Swift client System – Personal Budgets Report

Data is reported as the snapshot position of current clients at the quarter end.

Quarterly Performance Report Indicator
Bold Step Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Percentage	59.7%	54.3%	60.9%	57.5%	57.2%	58.9%	64.9%	67.2%
Target	**50%**	**54%**	**55%**	**57%**	**58%**	**60%**	**61%**	**63%**
Client Numbers	11416	10132	10549	10253	10453	10865	10612	11541
RAG Rating	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER	GREEN	GREEN

2. Proportion of Personal Budgets taken as Direct Payments



	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Direct Payments	24.1%	27.3%	26.3%	18.4%	18.4%	18.7%	19.4%	20.3%

Data Notes.
Units of Measure: Percentage of Personal Budgets taken as a Direct Payment
Data Source: Adult Social Care Swift client System – Personal Budgets & Direct Payments Reports

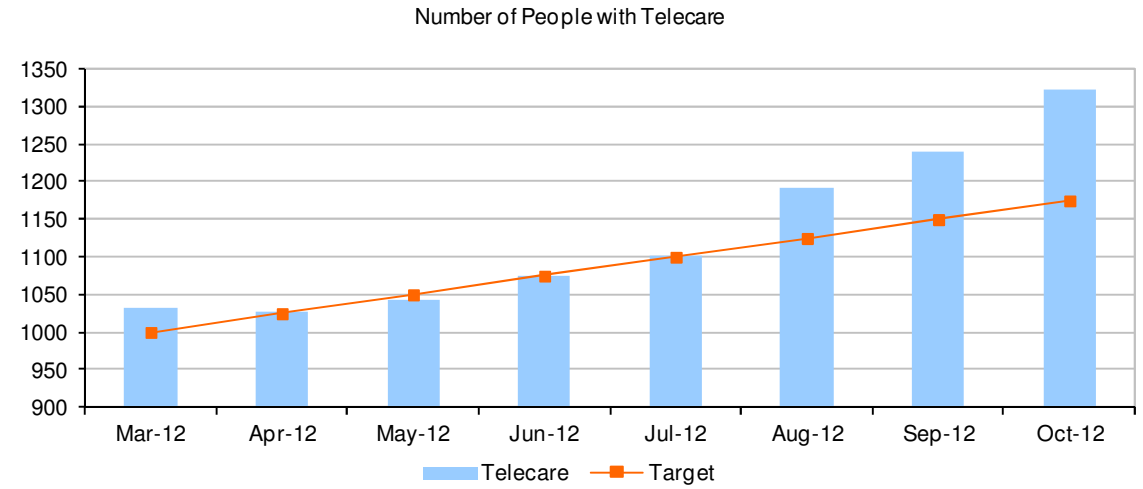
Bold Steps indicator

Commentary

The National target for personal budgets has been announced by the new Care Services Minister for April 2013, which has been based on feedback from Councils, including Kent, highlighting the real fact that not all people are eligible for personal budgets. For example, people who receive enablement services and return home with no further support, or equipment only will not have a personal budget.
There has been some significant progress in recent months with the allocation of personal budgets. This has been achieved through the teams focussing on reviewing clients and ensuring that support plans are in place. Updated review and support planning policies have been reissued, together with a simpler data collection process. The allocation of personal budgets is part of the review and support plan process.
Targets have been in place for the teams all year, which they are continuously monitored against. There are reports available for managers to use in supervision with their staff to ensure that clients are reviewed, have support plans and personal budgets. Continued emphasis and local monitoring of progress will continue, which will also ask Managers to raise training needs for both operational practice and system input in their teams so that this can be dealt with quickly.

The proportion of people who take their personal budget as a direct payment has increased in the last month. This indicator is not RAG rated because direct payments are a choice that service users take.

3. Number of adult social care clients receiving a telecare service			GREEN ⇧
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability/ Learning Disability and Mental Health



Data Notes.
Units of Measure: Snapshot of people with Telecare as at the end of each month
Data Source: Adult Social Care Swift client System

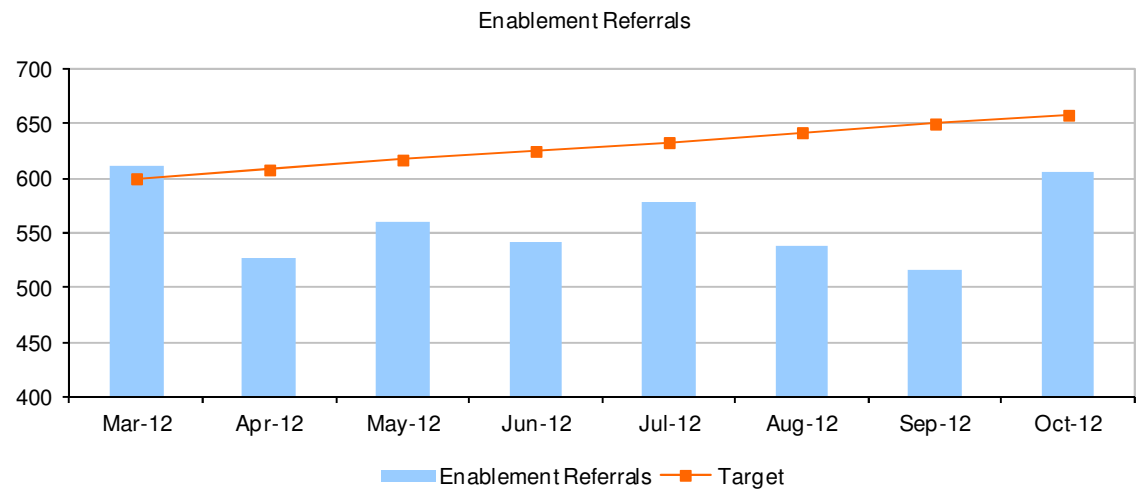
Quarterly Performance Report Indicator
Bold Step Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Telecare	1032	1027	1042	1074	1102	1192	1240	1321
Target	**1000**	**1025**	**1050**	**1075**	**1100**	**1125**	**1150**	**1175**
RAG Rating	GREEN	GREEN	AMBER	AMBER	GREEN	GREEN	GREEN	GREEN

Commentary

Telecare is now a mainstream service, after being managed centrally. The teams are now more experienced in considering telecare at every opportunity when assessing and reviewing clients as a means for maintaining independence. In addition, there is improved communication between the hospitals, the teams and the equipment store so data input is more timely. Targets have been set for all teams during the year, which are monitored on a monthly basis.

4. Number of adult social care clients provided with an enablement service			AMBER ⇧
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
Units of Measure: Number of people who had a referral that led to an Enablement service
Data Source: Adult Social Care Swift client System – Enablement Services Report

Quarterly Performance Report indicator
Bold Steps Indicator

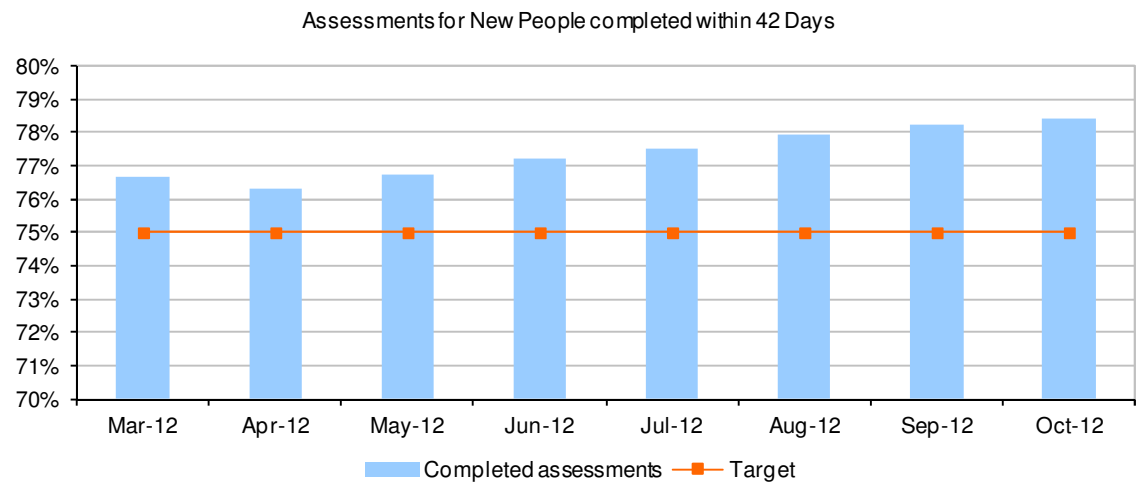
Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Enablement Referrals	612	527	560	542	579	538	517	605
Target	**600**	**608**	**617**	**625**	**633**	**642**	**650**	**658**
RAG Rating	GREEN	RED	AMBER	RED	AMBER	RED	RED	AMBER
% of new Referrals	45.6%	45.9%	48.2%	36.4%	39.2%	41.6%	41.8%	47.6%

Commentary

Referrals to enablement are not at the anticipated levels. Targets are set for each team to ensure that the provision of enablement is maximised. In order to address these lower levels, research into the availability of enablement places for people has been undertaken, together with an analysis of reasons for placements being refused. In addition, it is becoming apparent that other key services such as intermediate care, provision of equipment, including telecare and the Short term bed strategy may be reducing the overall need for enablement. The mapping of all these services will be undertaken to determine the impact of these interdependencies in the next couple of months and will be reported back to committee.

4. Number of adult social care clients provided with an enablement service	AMBER ⇧
In addition, the enablement service will be increasingly supporting more people directly from hospital in a more effective way. This will ensure that more people are able to access enablement more quickly. The target for 2012/13 is for 700 people per month to received enablement.	

5. Percentage of adult social care assessments completed within six weeks			GREEN ⇧
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



Data Notes.
Units of Measure: Percentage of assessments completed within 42 Days
Data Source: Adult Social Care Swift client System – Open Referrals without Support Plan Report

Quarterly Performance Report Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Completed	76.7%	76.3%	76.8%	77.2%	77.5%	78.0%	78.2%	78.4%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

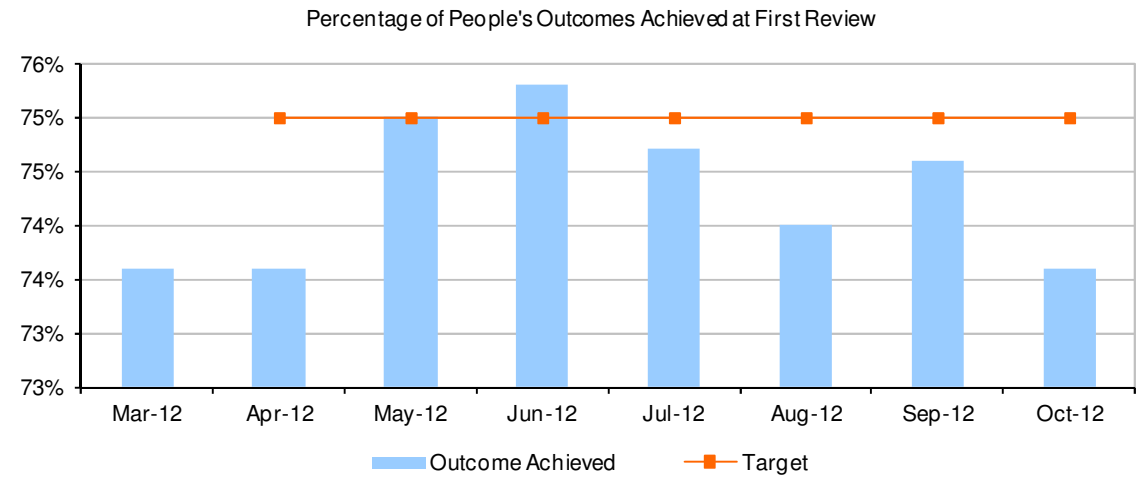
The target for 2012/13 remains 75%, which represents an acceptable balance between timely completion of assessments and the provision of enablement to new people.

This indicator looks at the timeliness of assessments. The aim of the indicator is not to ensure that assessments are completed more and more quickly – this would be detrimental to the individual if the enablement service was ended too soon.

This indicator serves to ensure that we have the right balance between ensuring enablement is delivered effectively and ensuring

5. Percentage of adult social care assessments completed within six weeks	GREEN ⇧
the whole assessment process is timely. To this end we have reviewed the target and would expect 75% of assessments to be within 6 weeks, and would challenge teams who would be either allowing people to spend too much time in an enablement service, or who were pushing people through the assessment process too quickly. Factors affecting this indicator are linked to waiting lists for assessments, assessments not being carried out on allocation and some long standing delays in Occupational Therapy assessments. There are also appropriate delays due to people going through enablement as this process takes up to six weeks and the assessment can not be completed until the enablement process is completed As with the other performance indicators, these targets are set across all the teams and monitored through the Divisional Management teams on a monthly basis.	

6. Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review			AMBER ⇩
Bold Steps Priority/Core Service Area	Empower social service users through increased use of personal budgets	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh/ Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability /Learning Disability and Mental Health



Data Notes.
Tolerance: Higher values are better
Unit of measure: Percentage
Data Source: Adult Social Care Swift client system

Data is reported as percentage for each quarter.

No comparative data is currently available for this indicator.

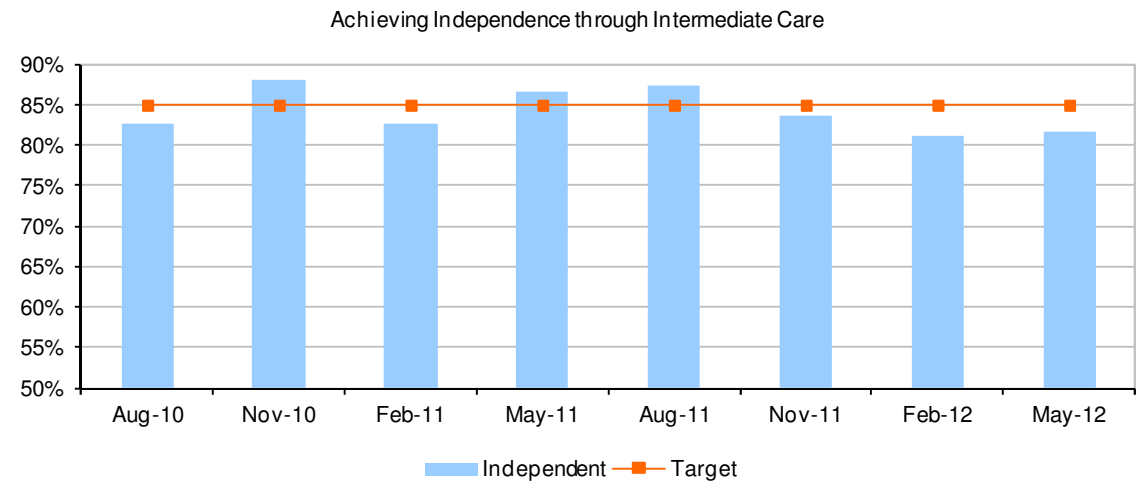
Quarterly Performance Report Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Achieved	73.6%	73.6%	75.0%	75.3%	74.7%	74.0%	74.6%	73.6%
Target	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating	RED	RED	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER

Commentary

The percentage of outcomes achieved has increased from 66% in March 2011 People's needs and outcomes are identified at assessment and then updated at review, in terms of achievement and satisfaction. Workshops will begin with the operational teams in January to provide additional training and guidance in respect of identifying outcomes.

7. Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			AMBER ⇧
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



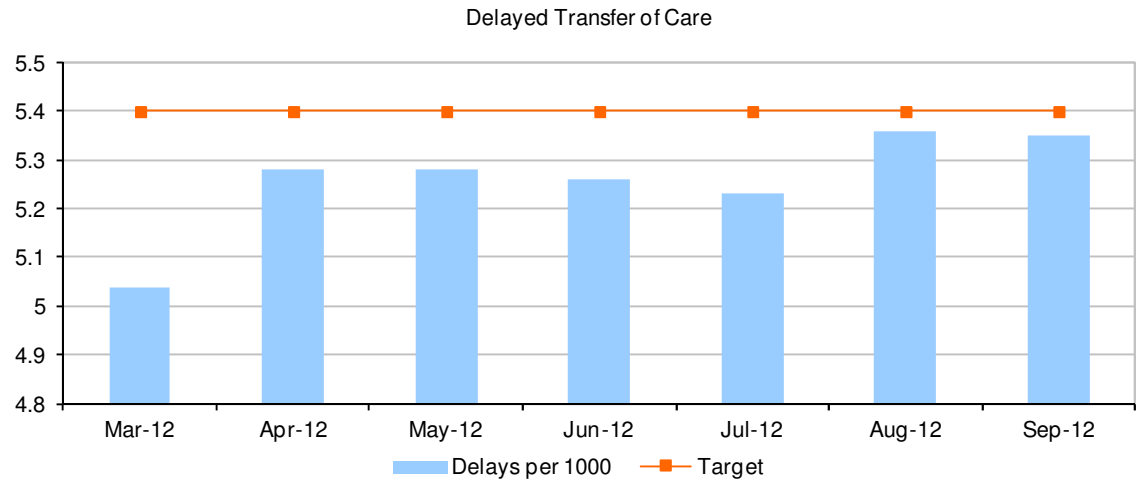
Data Notes.
Units of Measure: Percentage of older people achieving Independence and back home after receiving Intermediate Care following discharge from hospital
Data Source: Manual Data Collection

Trend Data	Aug 10	Nov 10	Feb 11	May 11	Aug 11	Nov 11	Feb 12	May 12
Percentage	82.7%	88.1%	82.6%	86.7%	87.4%	83.6%	81.3%	81.7%
Target	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**	**85%**
RAG Rating	AMBER	GREEN	AMBER	GREEN	GREEN	AMBER	AMBER	AMBER

Commentary

This indicator identifies where patients are **three months** after receiving intermediate care and relies on health and social care data being compared. There are about 400 referrals a month which are supported from hospital and into intermediate care. Performance has been lower in recent months, particularly in the west of the county, where there has been a reduction in the number of intermediate care beds. This position continues to be monitored, particularly in light of the increasing pressures being experienced from the hospitals, including ward closures and where there are some waiting lists for intermediate care, which can put pressure on the teams to make residential and nursing placements, l

8. Delayed Transfers of Care			GREEN ⇧
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People and Physical Disability



Data Notes.
This indicator is displayed as the number of delays per month as a rate per 100,000 population.

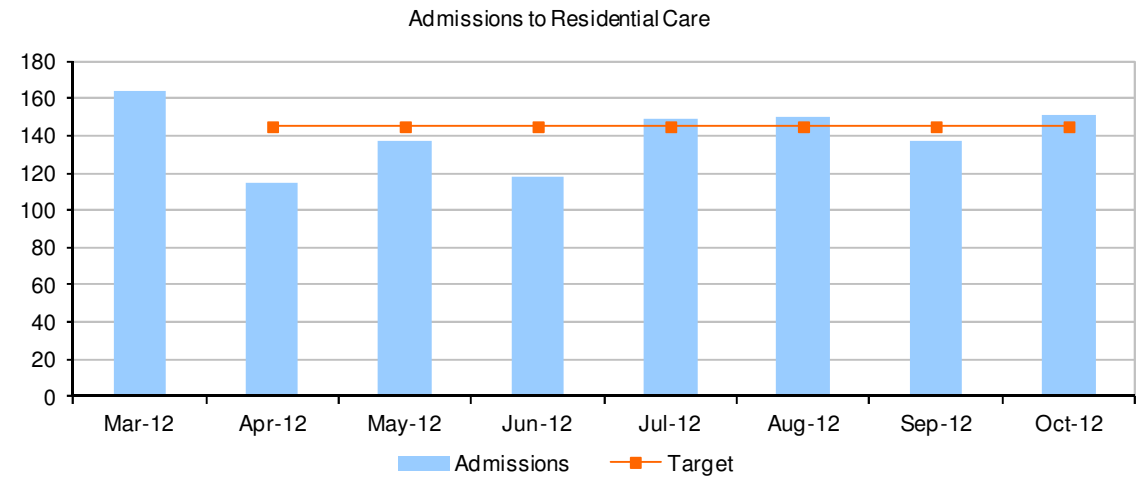
Bold Step Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12
People	5.04	5.28	5.28	5.26	5.23	5.36	5.35
Target	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**	**5.40**
RAG Rating	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

Delay transfers can be affected by many factors, mainly client choice and health based reasons. Whilst there are ongoing pressures to find social care placements, these have been eased with support such as intermediate care, and step down beds. Information relating to delayed transfers of care is collected from health on a monthly basis, and reasons for delays are routinely examined. Currently about 25% delays are attributable to Adult Social Care. The top three reasons for delays includes: Waiting NHS non-acute care, patient choice and then Social care assessment.

9. Admissions to Permanent Residential Care for Older people			AMBER ⇩
Bold Steps Priority/Core Service Area	Support the transformation of health and social care in Kent	**Bold Steps Ambition**	Put the Citizen in Control
Cabinet Member	Graham Gibbens	**Director**	Anne Tidmarsh
Portfolio	Adult Social Care and Public Health	**Division**	Older People & Physical Disability



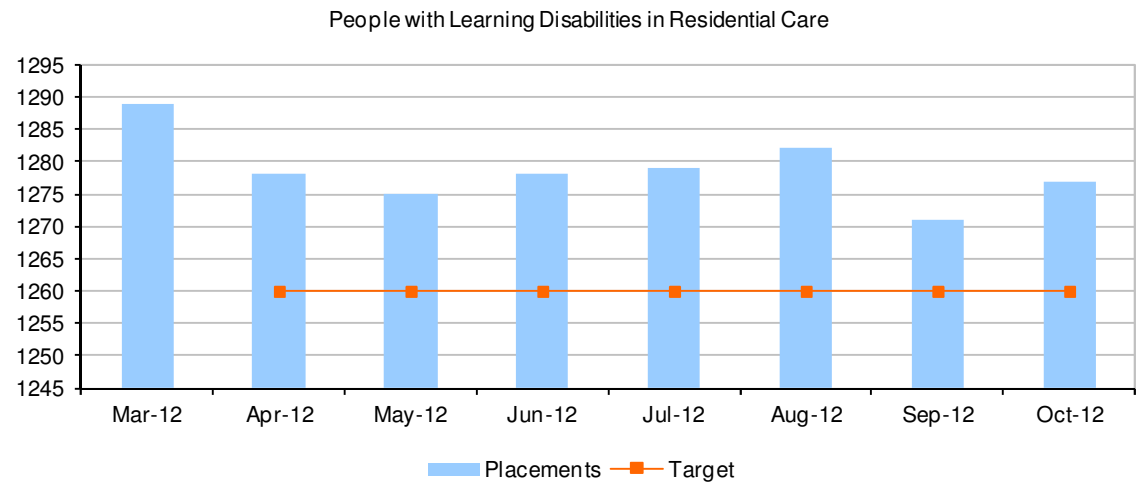
Data Notes.
Units of Measure: Older People placed into Permanent Residential Care per month.
Data Source: Adult Social Care Swift client System – Residential Monitoring Report

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Admissions	164	115	137	118	149	150	137	151
Target		**145**	**145**	**145**	**145**	**145**	**145**	**145**
RAG Rating		GREEN	GREEN	GREEN	AMBER	AMBER	GREEN	AMBER

Commentary

Reducing admissions to permanent residential or nursing care is a clear objective for the Directorate. Many admissions are linked to hospital discharges, or specific circumstances or health conditions such as breakdown in carer support, falls, incontinence and dementia. As part of the monthly budget and activity monitoring process, admissions are examined, to understand exactly why they have happened. The objectives of the transformation programme will be to ensure that the right services are in place to ensure that people can self manage with these conditions, and ensure that a falls prevention strategy and support is in place to reduce the need for admission. In the meantime, there are clear targets set for the teams which are monitored on a monthly basis, and an expectation that permanent admissions are not made without all other alternatives being exhausted.

10. People with Learning Disabilities in residential care			AMBER ⇩
Bold Steps Priority/Core Service Area	Improve services for the most vulnerable people in Kent	**Bold Steps Ambition**	To tackle disadvantage
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	Learning disability



Data Notes.
Units of Measure: Number of people with a learning disability in permanent residential care as at month end.
Data Source: Monthly activity and budget monitoring.

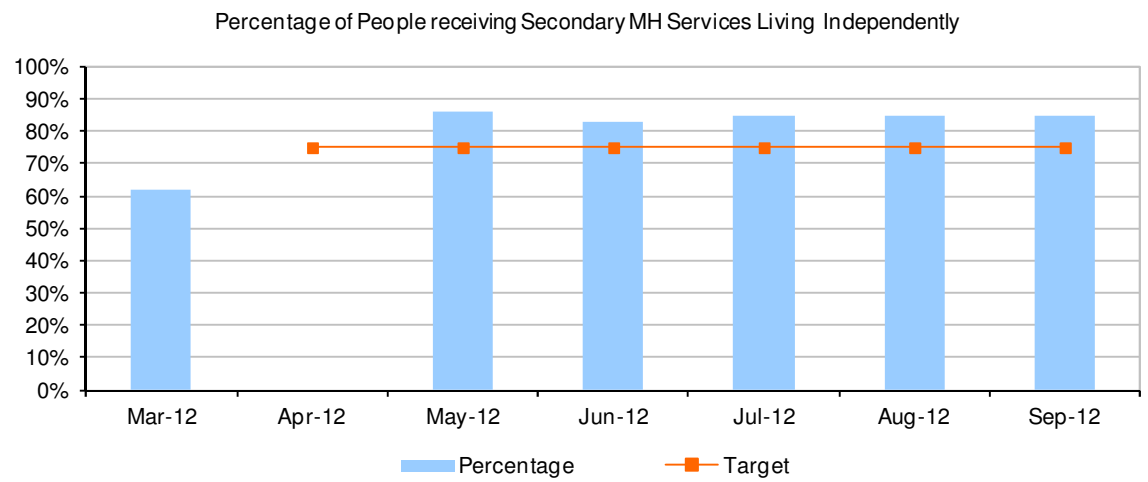
Bold Steps Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12	Oct 12
Placements	1,289	1,278	1275	1278	1279	1282	1271	1277
Target		**1260**	**1260**	**1260**	**1260**	**1260**	**1260**	**1260**
RAG Rating	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER	AMBER

Commentary

It is a clear objective of the Directorate to ensure that as many people with a learning disability live as independently as possible. All residential placements have now been examined to ensure that where possible, there will be a choice available for people to be supported through supported accommodation, adult placements and other innovative support packages which enable people to maintain their independence. In addition, the teams continue to work closely with the Children's team as young people coming into Adult Social Care through transition form the majority of the new residential placements.

11. Proportion of adults in contact with secondary Mental Health services living independently, with or without support			GREEN ⇩
Bold Steps Priority/Core Service Area	Improve services for the most vulnerable people in Kent	**Bold Steps Ambition**	To tackle disadvantage
Cabinet Member	Graham Gibbens	**Director**	Penny Southern
Portfolio	Adult Social Care and Public Health	**Division**	People with Mental Health needs



Data Notes.
Units of Measure: Proportion of all people who are in settled accommodation
Data Source: KPMT – quarterly

Bold Step Indicator

Trend Data	Mar 12	Apr 12	May 12	Jun 12	Jul 12	Aug 12	Sep 12
Percentage	62%		85.9%	83.1%	84.5%	84.7%	84.5%
Target		**75%**	**75%**	**75%**	**75%**	**75%**	**75%**
RAG Rating			GREEN	GREEN	GREEN	GREEN	GREEN

Commentary

This has been included for the first time, including data from KPMT and will be updated on a quarterly basis. Settled accommodation "Refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their *usual* accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence."
It provides an indication of the proportion of people with mental health needs who are in a stable environment, on a permanent basis.

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By: Jenny Whittle, Cabinet Member for Specialist Children's Services

Andrew Ireland, Corporate Director of Families and Social Care

To: Cabinet Committee – 11 January 2013

Subject: Children's Services Improvement Programme: Progress Update

Classification: Unrestricted

Summary

This report provides Cabinet with an update on progress regarding the Children's Services Improvement Programme.

Members are also asked to **NOTE** the very significant progress that has been made since the last report.

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1. Introduction

This is the fifth regular report to Cabinet Committee on progress made in implementing the Improvement Plan, and on improving practice and performance in services provided to children and care leavers in Kent. The last report was in July 2012, and outlined progress to that date. This report sets out the progress made over the past four months.

Please note this report was produced prior to the completion of the Ofsted Inspection of safeguarding. The first draft of the Ofsted inspection report will be sent to KCC for a factual accuracy check on 17 December 2012. The pre-publication report will be sent to KCC on 2 January, and the final report will be published by Ofsted on 4 January 2013.

2. Key Developments

A. Performance

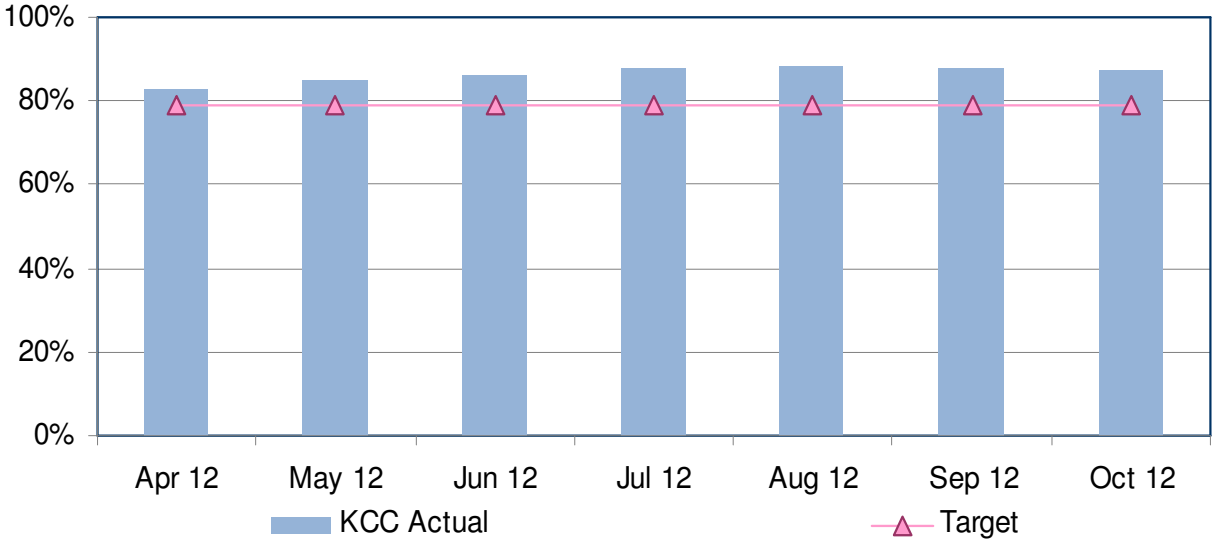
We have continued to sustain good progress across the key areas following the achievement of the August 2010 Improvement Notice targets.

Initial Assessments

The targets for Initial Assessments carried out within 7 days of referral, and targets for Initial Assessments in progress outside of timescale, continue to be exceeded – though there has been a month-on-month rise in the number of cases being progressed outside of timescale since June 2012. Performance over this period has been affected by the restructuring of the service - which has impacted on staffing levels, changed team dynamics and seen staff move to new roles. This reduction has been raised with managers for action – a message reinforced at the

quarterly Deep Dive performance surgeries. We also continue to build on the quality of casework undertaken whilst maintaining high levels of performance.

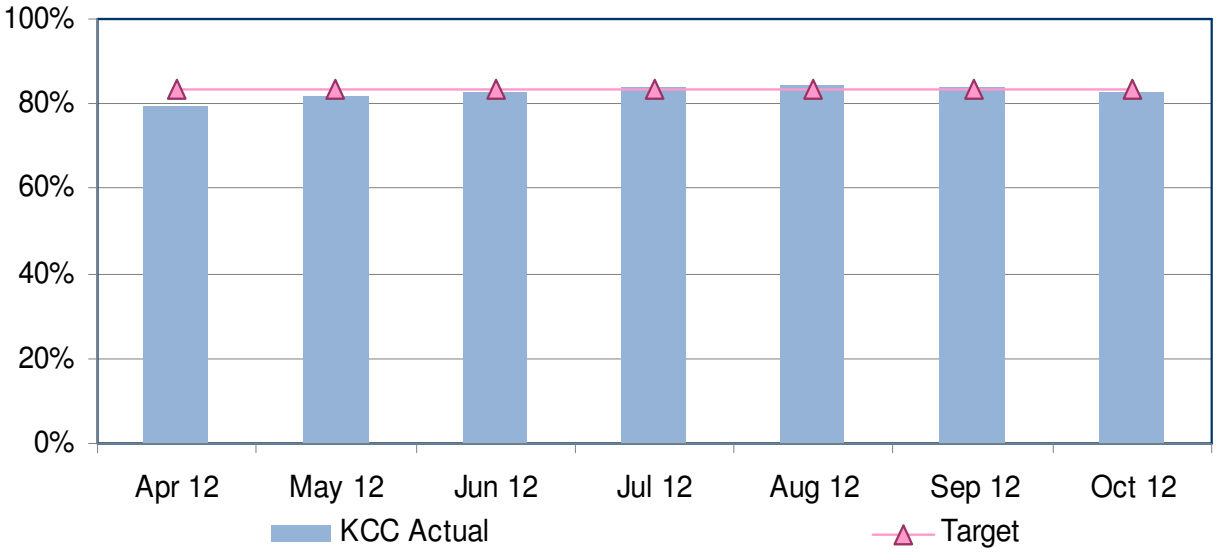
The graph below shows that the number of Initial Assessments completed within timescale over the last six months remains extremely high, with 87.5% of IAs being completed within 7 days of referral in October 2012:



Only 63 IAs were in progress outside of timescale in October – well below the Improvement Notice target of 200, and our more challenging internal target of 100.

Core Assessments

As with Initial Assessments, the number of Core Assessments being completed within timescale is high - with 83.1% being completed within timescale in October 2012, as shown in the graph below:



Though the target for the number of CAs in progress outside of timescale has proved challenging (with levels increasing between July and October 2012), figures have remained fairly level between September and October 2012, with 78 assessments remaining incomplete beyond 35 days in October – well within the Improvement Notice Target of 100.

Unallocated Cases

We continue to perform extremely well in terms of unallocated cases, with no cases of Child in Need remaining unallocated over 28 days since July 2012. No Child Protection or Children in Care cases have remained unallocated over 28 days since the Improvements took effect, and KCC continues to operate a zero tolerance policy on any such cases remaining unallocated over timescale. On the rare occasions that Children in Need cases remain unallocated over period, immediate action is consistently taken to address this, with the majority of the cases being allocated or closed as appropriate.

Further key performance achievements:

- The numbers of children on a child protection plan for two years or more has fallen consistently since June 2012, reaching 7.3% by October 2012 – our lowest level since April. Though we have not yet met the target for this indicator, the service are taking active steps to ensure timely decision making and the progression of all child protection cases through the management chain. Furthermore, the service is tracking the planned case conferences of children who have been subject to a child protection plan for 18 months to ensure that timely decision making and progression is occurring.

- In October 2012, the percentage of caseholding posts filled by permanent qualified social workers remained just below the target rate of 90% (at 88.4%), with the numbers of permanent filled positions increasing significantly between August and September 2012 - when the new structure was implemented. The service ensures it employs agency staff to fill any shortfall in permanent establishment figures.

- There have been sustained reductions in caseload levels since July. The county average caseload per caseholder is currently 17.6, well within the target level of 20 per caseholder.

B. Practice & Service Improvement

A number of developments have taken place since the last report was produced, including:

Service Restructure

The restructure of Specialist Children's Service has now been completed, and the new structure was fully implemented on 1 September 2012 (as was the new structure for Early Intervention and Prevention). The service is currently recruiting managers and staff to the remaining few posts, and it is aimed to have these vacancies filled by the end of the year/early in the new year. The recent Peer Review of the service commended the new structure as fit for purpose and as being popular with social care staff. The structure is still relatively new, and it is therefore too early to evidence outcomes or to quantify benefits at this time.

Practice Improvement Programme (PIP)

The PIP has been a key response to the practice failings identified by Ofsted. A small team of experienced and expert practitioners was assembled in January 2012, and deployed to each District in the county. PIP practitioners were tasked to work alongside practitioners, to audit their casework and to provide mentoring, coaching and training. This 'hands-on' approach was welcomed by staff and local managers, and the PIP findings been used to drive forward sustained

improvements in the teams and to further strengthen care planning. The PIP reports have also been used in the Deep Dive performance surgeries to add a qualitative/QA perspective to the quantitative data available in the performance scorecards. The PIP completed its programme of work in November 2012. There are now plans to launch a PIP 2, to consolidate the work of the first programme, in early 2013.

Commissioned Services

A range of early intervention services have been commissioned with robust performance and contract monitoring systems in place. The Intensive Family Support and Family Advice Service contracts were commissioned in July 2012, and the Emotional Health & Wellbeing; Adolescent Support Workers; Domestic Abuse; and Positive Relationships contracts were commissioned in September 2012. The Crisis Intervention contract was commissioned in October 2012. Training has been given to the newly commissioned providers to ensure there is a clear understanding of the CAF process, and of the role of these services to support families.

The Children's Commissioning Unit has further developed a Community Chest grant process aimed at providing support to vulnerable young people and families across Kent. The ambition for this grant is to provide short, one-off funding to local projects, based on the knowledge and evidence that locality teams are best placed to identify services that are responsive to local need. The grant process began in summer 2012.

Auditing

The County Audit Programme is ongoing, with all operational social work managers within Specialist Children's Services auditing at least one case per month. The findings - and any recommendations from these audits - are placed on the child's file, and have in some instances led some renewed manager attention and refocused work. The Safeguarding Unit is currently working to strengthen the consistency and quality of all audits undertaken.

The audit programme for 2013 has been developed and agreed. Safeguarding have incorporated/responded to the findings of the Peer Review in their development of the audit programme and audit tool. A programme of internal peer reviewing has also been agreed.

Virtual School Kent (VSK)

The VSK continues to provide an effective service for our Children in Care and care leavers. Having completed its restructure, the Virtual School has recruited 5 apprentice Participation Workers and 1 apprentice Administration Worker. These roles were ringfenced for care leavers, and the staff started in their posts in September 2012. This forms part of the work the VSK is undertaking to promote opportunities for Children in Care entering into employment. The VSK has also recently received the results of the information Ofsted inspection which took place in June. The 'thematic inspection' was extremely positive about VSK service

provision, and the full results are published in 'The impact of Virtual Schools on the Educational Progress of Looked After Children.'[1]

Academic indicators show that Kent's Children in Care have made further improvements in terms of educational attainment, with targets for Key Stage 2 and Key Stage 4 5 A*-C passes, including English and Maths, being exceeded. There also continues to be an increase in the percentage of health care assessments for Children in Care, with 92.2% of children receiving assessments within timescale in October 2012. There has been a dip in dental checks within timescale over the same period (88.1% against the target 90%), though performance data shows there is evidence of an improving trend.

The electronic Personal Education Plan (ePEP) was launched on 1 September 2012. The VSK is on track to ensure that 95%+ of CIC of statutory school age to have a current PEP that has been quality assured by the locality assistant heads by the Improvement Plan delivery deadlines.

Further key practice and service achievements:

- Access to Resource Panels (placement panels) are now functioning in all four Areas. The Panels regulate the decision making processes regarding the need for children to become Looked After. This should ensure that decision making is consistent, timely and is based on sound assessment.
- The Peer Review of the service took place between 24 and 28 September 2012. Feedback from this assessment was generally positive, and areas that were highlighted as requiring further attention are now being addressed e.g. additional capacity in the Central Duty Team. Staff Briefings took place in October to inform the service about the feedback KCC received, and to encourage staff to take personal responsibility for improving the service - building on the strengths and areas of weakness identified by the Review, responding on an individual/team/Area basis.
- The Recruitment Campaign was launched in September 2012. The campaign included a KCC sponsored recruitment event took place in London on 12 November 2012. The event was well received, and applications/data are being monitored to see whether the event has an impact on recruitment figures.
- The Coram Adoption Improvement Action Plan was signed off by the Adoption Board in October 2012.
- Integrated Adolescent Teams, including in-house provision of 16+ services, are being piloted in 4 Districts from September 2012.
- All children subject to a CP Plan for 2yrs+ are in the process of being reviewed by a new CP Chair. Recommendations will be made to the service to ensure effective progression.
- The TRP (ICT upgrade programme) has now been completed for Specialist Children's Service staff. All managers, practitioners and support staff now have the appropriate up-to-date equipment in order to meet their business needs.

[1] The impact of Virtual Schools on the Educational Progress of Looked After Children.' Oftsted, 11 October 2012. < http://www.ofsted.gov.uk/resources/impact-of-virtual-schools-educational-progress-of-looked-after-children>

3. Phase 3 Plan

The Phase 3 Improvement Plan was launched on 1 August 2012, and will take the service through until August 2013. The aim of the Phase 3 Plan is to deliver a whole system approach to managing family pathways from early help to statutory intervention. This tranche of the Improvement Programme will continue to focus on quality and sustainability (as did the Phase 2 Plan), whilst embedding the efficiency and effectiveness of improved service provision into everyday working practice, and laying the foundations for cultural change.

The themes for the next tranche of the Plan are as follows:

1. Realise our vision to ensure that all staff are dedicated to delivering the highest quality of practice which is responsive to service user need
2. Improve the quality of assessment and planning to ensure that decision making is timely and child-centred
3. Strengthen a range of preventative services to avoid unnecessary family breakdown
4. Improve care planning and outcomes for Looked after Children
5. Improve care planning and outcomes for children subject to Child Protection Plans

Phase 3 is designed to build on the new structure, to ensure reduced and managed workloads, and to provide increased stability in the workforce. This tranche is focused more and more on practice standards and on building a long term quality service. This period is understood as moving from 'improvement to transformation'.

4. Vision

Senior officers from ELS, FCS and Communities and Customers have been working together to construct a transformational vision and strategic plan for all children and for all services in the County. This will cover the whole range of provision from universal to the very specialist, and will seek to set out a set of fundamental changes that will improve outcomes for all.

To underpin this, a social work contract is currently being developed; this contract will set out a programme of change that will enable - and expect - practitioners to become more effective in their work with children and families; it will also ensure that the necessary organisational and infrastructure changes are in place to support staff in doing this. It is anticipated that this contract will provide improved stability in relation to staffing, reinforce the major investments that are being made in ICS/ICT changes, and reinforce the substantial management and supervision training inputs - consistent with Professor Munro's recommendations. This contract will also set out more explicit roles for the Principle Social Workers (which will be recruited to in early 2013), and will form the basis of our response to the new flexibilities expected in the revised version of 'Working Together'.

5. Financial Implications

£1M has been allocated to support the improvement programme in the 2012/13 financial year. However, £251K has been deducted at source to offset the pressures

brought about by the improvements to staff office accommodation and parking (Core Task 10 project), originally to be covered by P&IS.

An additional grant is being sought from the Children's Improvement Board, to pay for further improvement works (such as the Phase 2 Practice Improvement Programme).

6. Bold Steps for Kent and Policy Framework

Improving Children's Services continues to be one of the Council's top priorities, following the Ofsted Inspection in August 2010.

7. Legal Implications

The Secretary of State has the power to issue a statutory intervention notice if he or she deems this is required to secure the necessary improvements within a failing service.

8. Equality Impact Assessments

There are no issues to report on this.

9. Risk and Business Continuity Management

A risk register has been established and maintained, and is reported regularly to the external Improvement Board.

Key strategic risks we need to mitigate against are:

- A failure to recruit and retain experienced social care staff and managers to KCC
- Numbers of Looked After Children may continue to increase with impacts on staffing resources and outcomes for children
- That the capacity and skill set of the quality assurance and evaluation sub group is sufficient to meet the needs and demands of the KSCB
- Delay to the implementation of the new ICS system to the revised timescales
- Untoward safeguarding incidents

10. Consultation and Communication

The programme will continue to communicate with staff, managers, KCC Members, the Children's Service Improvement Panel, KCSB and the External Improvement Board on improvement achievements and challenges.

11. Inspection

The service has been inspected between 26th November and 6th December 2012. This inspection was conducted under the new regime, which has been changed to reflect the recommendations of Professor Munro's report into child protection provision. This new regime focuses solely on safeguarding (inspections into Children in Care are also being re-constructed but will now be delivered separately from those into Safeguarding) and in particular is now much more focussed on the quality of

front-line practice. As such, inspectors will track the child's journey from referral into early intervention services and through social care provision (whether through Children in Need or Child Protection systems) and back out to lower level or universal services. They are likely to look at around 200 randomly selected cases.

It is anticipated that the results of the inspection will be published in January 2013 after the Cabinet Committee's meeting. It is very much hoped that the findings will reflect the significant progress which has been made over the past 27 months.

12. Conclusion

The Council has continued to make progress over this period. Good performance has been sustained, and SCS are attaining the vast majority of the targets set out in Kent's Improvement Notice. Those areas which are proving challenging are being robustly addressed, through a combination of performance and quality assurance measures. It is felt that the new service vision, and the development of an emergent culture of aspiration rather than acceptance, very much establish us on the right path to achieving our objectives in the near future.

Recommendations

Members are asked to NOTE this report.

Contact officer:

Jennifer Maiden-Brooks, Programme Manager, Families & Social Care Improvement Team

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Background Documents: None

By: Graham Gibbens, Cabinet Member Adult Social Care and Public Health

Meradin Peachey Director of Public Health

To: Social Care and Public Health Cabinet Committee – 11 January 2013

Subject: **Health Improvement Programmes Performance Report**

Classification: Unrestricted

Summary: **This performance report provides an update of Public Health performance, particularly on the two programmes highlighted specifically in the NHS Operating framework (Health Checks and Stop Smoking Services) and also the services that are mandated.**

1. Introduction

Part of the NHS reforms is the move of Public Health to the local upper tier Local Authority, and the move to the Local Authority of a ring fenced budget for health improvement.

This report shows performance to date on the majority of Public Health: Health Improvement programmes which will move to Kent County Council from 1st April 2013

The report is presented in a dashboard style, with the individual performance targets RAG (red, amber, or green rated)

3 Exception Reports

1. Smoking Quits

Data presented is for progress to date for Quarter One of the new financial year. This now shows achievement of the Q1 target.

Work continues with the provider Kent Community Health NHS Trust (KCHT) to ensure the problems referred to at the July Committee meeting are addressed and the service continues to meet its target.

A verbal update will be given on progress to date.

2. Health Checks

The target set for the service with the SHA continues to be challenging for 2012/13 with quarterly projections highest in the first two quarters of the new financial year (these are based on evidence of uptake in longer running programmes). The east of the county are now achieving both

the number of invites target and the number of health checks received target, the west continue to work to get the number of practices involved and started. However progress has moved from a red rating to amber which demonstrates progress.

Health Checks is a five year rolling programme with the expectation that 20% of the total cohort eligible for a health check will have been offered a health check annually. Thus it will take five years for us to reach the 100% mark

Full investment by both NHS Eastern and Coastal Kent and NHS West Kent for 2012/13 means that we should reach the target agreed with the SHA.

Nationally, the England average of 7.6% of the cohort invited in Q2, in Kent the average is 8.4%.

3. Breast Feeding Initiation

There has been a gradual improvement in Q2 of the recording of breastfeeding initiation rates. There is an on-going issue of data transmission between GP practices and the Child Health Recording System in the east of the county. We are working with the provider to resolve this.

4. Recommendations

Members are asked to note the report

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Background information Nil

Public Health Performance Report Dashboard

	Programme	Target	Achieved	RAG	
1	**Smoking Quits**				
	Nos of people successfully quitting: Annual Target				
	Nos of people successfully quitting: Progress against Q2 Target	4,014	3,694	A	
	Service delivered by Kent Community Healthcare NHS Trust, target agreed with Public Health and relates to people who have set a quit date and suceesfully quit at the four week follow up				
	Service runs across the financial year, data runs 10 weeks in arrears				
2	**Health Checks**				
	Number of Invites for Health Checks	45,620	37,667	A	
	Number of Health Checks completed		13,571	A	
	Service delivered by numerous providers, with GP practices being the fundamental building block of the programme. The programme is a five year rolling programme for 40 to 74 year old people who are invited for a vascular health check once every five years, except if they are already on a vascular disease register				Q2 Submission
	Service runs across the financial year, data runs six weeks in arrears				
3	**Sexual Health**				
	GUM Access	95%	98%	G	
	Chlamydia Screening Uptake rate	35%	10.00%	A	
	Chlamydia Screening Positivity	7%	6.80%	A	
	Access to Genito-Urinary Medicine is an important element in reducing the rise in the incidence and prevalence of sexually transmitted disease; the target is 95% of patients offered an appointment to be seen within 48 hours. Chlamydia screening is an opportunistic screening programme targeting sexually active people aged between 15 and 24 years. Emphasis of the programme has been on Uptake rate with a national target of 35% of the eligible population. Emphasis in future years is to be based on positivity ensuring individuals at risk are screened.				progress for Q2 2012/2013
	Service runs across the financial year, data runs 8 weeks in arrears				
4	**National Childhood Measurement Programme**				
	Measurement Reception Year	85%	94%	G	
	Measurement Year 6	85%	95%	G	
	The National Child Measurement Programme (NCMP) is an annual programme to measure the height and weight of all children in Reception and Year 6. The aim of the programme is to provide the national statistics on obesity within the two cohorts with a target of measuring at least 85% of eligible children, and to provide direct feedback to parents on their children's healthy weight				2011 to 2012 outturn
	The service runs over the acdemic year, with the service uploading to a national data repository				
5	**Healthy Schools***				
	Achievement of Healthy School Status	98%	97%	A	
	Engagement in the enhancement model	40%	44%	G	
	Healthy Schools is undergoing review with the service currently to look at a future model of delivery which supports reduction in teenage conceptions, reduces young people's smoking and susbstance misuse prevalence, reduction of unhealthy weight together with emotional health and wellbeing*				to Q2 2012/13
	The service runs over the acdemic year.				
6	**Breast Feeding Initiation**				
	coverage rates (the percentage of ascertainments of breast feeding status)	95%	94%	A	
	6-8 week breastfeeding rates (prevalence)	46%	40%	A	
	Breastfeeding newborn babies is evidenced to improve long term outcomes, for both mother and baby; this target measures both the ascertainment of breastfeeding status and the prevelance of initiation and maintainence of breastfeeding for 6-8 weeks. The 6-8 week target is relatively new and has required detailed work with midwives, health visitors and GP practices to ensure robust reporting				Q2 2012-2013
	The service runs over the financial year, data runs two months in arrears				
7	**Health Trainers**				
	Number of new contacts	1,250	1,687	G	
	The Health Trainers Programme is commissioned to help people in our most deprived communities to develop healthier behaviour and lifestyles. HTs offer practical support to change individual's behaviour to achieve their own choices and goals. This involve encouraging people to: stop smoking, participate in increased physical activity eat more healthily, drink sensibly and/or practice safe sex. The service not only seeks new clients, but ensures existing clients have personalised written care plans and, where appropraite, are signposted to other services.				to Q2 2012-2013
	Service runs across the financial year, data runs 6 weeks in arrears				

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By: **Graham Gibbens – Cabinet Member for Adult Social Care and Public Health**

Andrew Ireland – Corporate Director, Families and Social Care

To: **Social Care and Public Health Cabinet Committee – 11 January 2013**

Subject: **KENT AND MEDWAY SAFEGUARDING VULNERABLE ADULTS ANNUAL REPORT APRIL 2011 – MARCH 2012**

Classification: Unrestricted

Summary: This report introduces the Kent and Medway Safeguarding Vulnerable Adults Annual Report April 2011 – March 2012, which details the work of the multi-agency partnership and how it managed safeguarding adults issues in 2011-2012. The report provides safeguarding activity information and also contains key statements from partner organisations regarding how they dealt with safeguarding issues in their respective agencies.

Recommendations: Members are asked to NOTE and COMMENT on the attached report.

1. Introduction

(1) Safeguarding Adults continues to be a major priority of the Families and Social Care Directorate. In meeting this responsibility, it is essential that the Directorate plays a key role in the workings of the Kent and Medway Safeguarding Vulnerable Adults Executive Board.

(2) During 2011-2012, the Kent and Medway Safeguarding Vulnerable Adults Executive Board comprised of Senior Officers from the key agencies in Kent and Medway involved in safeguarding, including the Police, Health Service, Medway Council and Kent County Council. The current chair of the Board is the Corporate Director of Families and Social Care, Kent County Council.

(3) The Annual Report is retrospective, covering the period of April 2011 – March 2012. The content of the Annual Report includes statements from partner agencies, key safeguarding activity information and outlines key priorities for 2012-2013.

2. Financial Implications

(1) There are no direct financial implications arising from the report.

3. Bold Steps for Kent and Policy Framework

(1) The work of the Kent and Medway Safeguarding Vulnerable Adults Executive Board, which is detailed within the Annual Report, plays a key role in supporting Priority 14 of Bold Steps for Kent:

"Ensure we provide the most robust and effective public protection arrangements".

4. The Report

(1) The report contains a wealth of information from each of the key agencies engaged in the Kent and Medway Safeguarding Vulnerable Adults Executive Board. The following paragraphs give a brief overview of key sections of the report.

(2) **Section 2** provides a pen picture of Kent and Medway.

(3) **Section 3** summarises the nationally significant activity regarding safeguarding.

(4) **Section 4** details the locally significant activity in relation to safeguarding.

(5) **Section 5** of the report outlines the multi-agency safeguarding training programme supported by the Kent and Medway Safeguarding Vulnerable Adults Executive Board. This section highlights activity and progress towards the training review implementation plan.

(6) **Section 6** provides details of the funding arrangements for the Kent and Medway Safeguarding Vulnerable Adults Executive Board.

(7) **Section 7** summarises the work of each member agency of the Kent and Medway Safeguarding Vulnerable Adults Executive Board.

(8) **Section 8** outlines the activity data for adult safeguarding in Kent and Medway. This includes referral data, the background data in regard to victims and the current trends in relation to adult safeguarding in Kent and Medway.

(9) **Section 9** identifies the key priorities for the Kent and Medway Safeguarding Vulnerable Adults Board for 2012-2013.

5. Conclusion

(1) The Annual Report provides a retrospective view of the work of the Kent and Medway Safeguarding Vulnerable Adults Executive Board and details key safeguarding activity between April 2011 – March 2012.

6. Recommendations

(1) Members are asked to NOTE and COMMENT on the attached report.

7. Background Documents

(1) None

8. Contact Details

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Appendices

Appendix 1: Kent and Medway Safeguarding Vulnerable Adults Annual Report: April 2011 – March 2012

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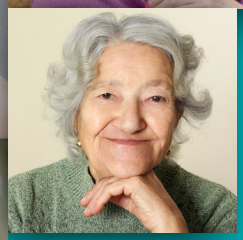
KENT AND MEDWAY

Safeguarding Vulnerable Adults



ANNUAL REPORT

April 2011 - March 2012

Contents

Foreword

As chair of the Kent and Medway Safeguarding Vulnerable Adults Executive Board, I am pleased to introduce our Annual Report for 2011-2012.

Throughout the year, we have continued to meet and plan for a range of challenges. This year, there have been major changes taking place within partner agencies. Additionally, other partners involved in adult safeguarding have expressed a desire to have a stronger voice on the Board. In response, the Board has undertaken a full governance review. The overall aims of the review have been to improve the Board's engagement with all providers, particularly in Health; ensure that the voice of service users and carers is heard and to consider the future role of Clinical Commissioning Groups within the Board. The recommendations of the review will be finalised in 2012-2013. In particular, this will include a revised structure of the Board, which will ensure there is wider membership. The Kent and Medway Safeguarding Vulnerable Adults multi-agency partnership is underpinned by principles and values in Appendix 1.

At the time of writing this report, the Care and Support Bill has recently been published (July 2012) for consultation. The Bill proposes creating a new statutory framework for adult safeguarding and we look forward to the outcome of the consultation period.

Finally, I would like to take this opportunity to thank everyone for their contribution to the work of the Executive Board, Executive Team and associated working groups and for their continued commitment to safeguarding vulnerable adults in Kent and Medway.

Andrew Ireland
Corporate Director – Families and Social Care, Kent County Council
Chair of the Kent and Medway Safeguarding Vulnerable Adults Executive Board

1 What is abuse?

In 2000 the Government published 'No Secrets'. This required local authorities to set up a multi-agency framework to ensure not only a coherent policy for the protection of vulnerable adults at risk of abuse, but also a consistent and effective response to circumstances that gave grounds for concern. It gave local authorities a role in co-ordinating safeguarding activities.

'No Secrets' defines a vulnerable adult as:

A person aged 18 years or over "Who is or may be in need of community care services by reason of mental or other disability, age or illness: and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation",

And abuse as:

"A violation of an individual's human or civil rights by any other person or persons".

Both definitions have been adopted in the Kent and Medway Safeguarding Vulnerable Adult's Multi-Agency Policy, Protocols and Guidance.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable adult is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person. The main forms of abuse are outlined in Appendix 2.

Abuse can happen anywhere and take place in any context, for example, in someone's own home, in nursing, residential or day care settings, in hospital, in public places or in custodial situations.

Vulnerable adults may be abused by a range of people including relatives, neighbours, other service users, professional workers, friends and strangers.

The Department of Health has stated that forthcoming legislation will refer to adults at risk 'of harm' and not as previously proposed adults at risk of 'significant harm'.

2 Pen Picture of Kent and Medway

KENT

(The following figures refer to the KCC area which excludes the Medway Unitary area).

Kent ranks 102nd out of 152 county and unitary authorities in the English Indices of Deprivation 2010 (ID2010). This places Kent within England's least deprived third of authorities as a rank of one indicates the most deprived area. However, there are areas within Kent that do fall within the 20% most deprived in England. Overall, Kent suffers the most from Barriers to Housing and Services deprivation and suffers the least from Health Deprivation and Disability[1].

With a resident population of just over 1.4 million[2] Kent has the largest population of all of the English counties. People living in urban areas make up 71% of the Kent population but they only occupy 22% of the total land area. The remaining 29% of the population live in rural areas but occupy 78% of the land in Kent[3].

Over the past 10 years Kent's population has grown faster than the national average. The population of Kent has grown by 7.8% between 2000 and 2010, above the average both for the South East (6.7%) and for England (6.1%)[4]. Kent's population is forecast to increase by a further 10.9% between 2010 and 2026[5].

Overall the age profile of Kent residents is similar to that of England. Just under a fifth of Kent's population is of retirement age (65+). Kent has an ageing population. Forecasts show that the number of 65+ year olds is forecast to increase by 43.4% between 2010 and 2026, yet the population aged under 65 is only forecast to increase by 3.8%.

The largest ethnic group in Kent is White. 92.4% of all residents are of white ethnic origin and 7.6% are of Black Minority Ethnic (BME) origin. The largest single BME group in Kent is Indian representing 1.9% of the total population[6]. 75.1% of Kent residents describe themselves as Christian, whilst the largest non-Christian religious group is Sikh (0.6%).

70% of Kent residents describe themselves as being in good health and 16.5% of Kent's population live with a limiting long term illness[7].

MEDWAY

(The following figures refer to the Medway area).

There were approximately 256,700 people resident in Medway in 2010, based on estimates from the Office for National Statistics. This is a 2.8% increase since 2001. The average age of residents in Medway is lower than nationally, however since 2001 the age gap has narrowed with Medway's average age increasing faster than that of England and Wales.

Compared to England and Wales, the population of Medway has a slightly smaller proportion of people over the age of 65 years. The number of residents aged over 60 has increased by one fifth since 2001. It is estimated that from 2012 to 2021 the number of people aged 65 and above will increase by 22% to 47,000 and the

1 Deprivation in Kent report
2 2010 Mid-Year Population estimates bulletin
3 2010 Ward level population estimates bulletin
4 2010 Population pyramids bulletin
5 KCC Strategy (Oct.2011) interactive population toolkit
6 2009 Mid-year ethnic population estimates
7 2001 Census profile

number of people over 85 years will grow by 39% to 6,100 in 2021. In the next five years the estimated number of people aged over 65 will increase by 4,500 people (17.5%).

From 2009 to 2020 the number of people over 65 years with a limiting long-term illness is expected to increase by 31%.

People aged 85 and over make up only 1.6% of Medway's population (4,136 people according to 2010 estimates). People aged 85 years old and older are particularly vulnerable because they are more likely to be frail and have mental health problems such as dementia.

The number of people over 65 years with a limiting long-term illness is expected to increase by 25% from 2011 to 2020 assuming the age-related prevalence from the 2001 Census is constant in the future. This will have a significant impact on the demand for health services for the management of long-term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age. There will also be a need to increase preventative programmes such as influenza vaccination for the over 65s Medway is ranked 132nd most deprived local authority area out of 325 in England, according to the Index of Multiple Deprivation. At a ward level the area is mixed; it has both the most affluent and some of the most deprived areas in the country with 23 neighbourhoods in Medway being in the 20% most deprived areas nationally.

The majority of the population in Medway (90.6%) is classified as White, with the next largest ethnic group being Asian or Asian British (4.0%). The proportion of the population that is White is slightly larger than in England and slightly lower than in Kent, although these differences are not significant. There are also no significant differences in ethnicity by gender.

3 National Context

A number of documents published in 2011 - 2012 influence the safeguarding agenda. They include:

Safeguarding Adults - The Association of Directors of Adult Social Services (ADASS) Advice Note (April 2011)

This document outlined a number of recommendations:

- Language and terminology - ADASS supports the Law Commission's proposal to amend the No Secrets definition of "vulnerable adult" to "adult at risk" and endorses the term 'harm' and 'significant harm' as being more descriptive than 'abuse'
- Leadership - the framework recommends that every council should have a council-wide approach to safeguarding adults embedded within its overall policy framework
- Safeguarding Adults Boards - ADASS supports the placing of Safeguarding Adults Boards on a statutory footing and a duty of partners to co-operate, including GP Consortia
- Adult Social Care, personalisation and empowering people - ADASS is of the view that we now need to develop further a range of approaches and services to support and empower 'vulnerable' or 'at risk' people to improve outcomes and their experiences
- Workforce Development - ADASS states that managers in Adult Social Services need to be confident and competent leaders in adult safeguarding, able to bridge and deliver policy into practice, supervise and support staff to achieve positive outcomes for citizens and carers

(http://www.adass.org.uk/images/stories/Safeguarding%20Adults/SafeguardingAdviceNote0411b.pdf)

Carers and Safeguarding Adults - Working Together to Improve Outcomes Review Paper ADASS Advice Note (April 2011)

This review identified seven key messages ADASS wanted people to consider:

- Leadership - safeguarding is everybody's business with Directors and local Boards listening, learning as well as leading on improved safeguarding outcomes and outcomes for carers
- Partnership - Safeguarding Adults Boards engage with carers and local stakeholders and work together for better safeguarding practice and outcomes for those involved in safeguarding processes
- Empowerment - carers have access to information, advice and advocacy that is understandable and empowers them to share
- concerns and change harmful circumstances
- Prevention - community engagement, public and professional awareness is encouraged and accessible, and understandable information is available to carers that reduces risk of abuse
- Recognition and reporting - partnerships and practitioners understand the barriers to recognition and reporting and work in partnership to overcome them and ensure access to justice
- Protection and proportionality - responses have the person concerned at their centre and enable those at risk to inform outcomes linked to proportionate and protective services and supports. Risks are managed and harmful and abusive situations stopped
- Learning and accountability - impacts are understood, practice monitored and safeguarding experiences and outcomes monitored to learn from the experiences of carers and people at risk of harm and those who seek to help them. Staff have the competencies and operational culture to support this.

(http://www.adass.org.uk/index.php?option=com_content&view=article&id=747:abuse-by-and-against-carers-rare-events-that-need-community-and-professional-vigilance&catid=146:press-releases-2011&Itemid=447)

Statement of Government Policy on Adult Safeguarding - May 2011

The document set out the Government's policy on safeguarding vulnerable adults. It included a statement of principles for use by local authority social services and housing, health, the police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. The principles are:

- Empowerment - presumption of person-led decisions and informed consent
- Protection - support and representation for those in greatest need
- Prevention - it is better to take action before harm occurs
- Proportionality - proportionate and least intrusive response appropriate to the risk presented
- Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability - accountability and transparency in delivering safeguarding.

(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126770.pdf)

Law Commission Report on Adult Social Care - May 2011

This report made the following key recommendations in relation to safeguarding vulnerable adults:

- The term 'adult at risk' should be used instead of 'vulnerable adult'
- An 'adult at risk' is defined as anyone with social care needs who is or may be at risk of significant harm
- Future adult social care law should be placed on local authorities to investigate and take appropriate action if there is reasonable cause to suspect that an adult is at risk. Councils will have a legal duty to investigate suspected instances of adult abuse when an adult is at risk of harm
- Councils will take a lead role in multi-agency safeguarding procedures
- Social Services need to establish an adult safeguarding board and should specify the functions and membership of the board, a requirement to share information and duty to contribute to Serious Case Reviews. NHS trusts and police will be required to appoint representatives to adult safeguarding boards
- Promote co-operation between the organisations in safeguarding adults from abuse and neglect

(http://lawcommission.justice.gov.uk/docs/lc326_adult_social_care.pdf)

4 Local Context

In September 2011 the Kent and Medway Safeguarding Vulnerable Adults Executive Board commissioned a review of the multi-agency safeguarding governance arrangements. (Details of the current governance structure can be found in Appendix 3). Although there had been a restructure of the Safeguarding Vulnerable Adults Board in 2010, there have since been further changes in the partner agencies and the environment in which they operated. The review is aiming to improve its engagement with all providers, particularly in health, ensure that the voice of service users and carers are heard and consider the role of Clinical Commissioning Groups and the Board. Terms of reference for the review were approved by the Executive Board and a consultation workshop was held in February 2012. A revised structure is currently being developed for the Board to consider and approve when it meets in June 2012.

Membership of the Executive Board changed in 2011 – 2012 with a new Chair – the Corporate Director of Families and Social Care in KCC and a new representative from Kent Police. The health representative on the Board also took on the role of Chair of the Executive Team.

In June 2011 the Executive Board commissioned a Serious Case Review (SCR) chaired by Professor Hilary Brown from Canterbury Christ Church University. The final report and recommendations will be endorsed by the Board in May 2012. Following the SCR, work will begin on revising the Kent and Medway SCR protocols.

The Kent and Medway Safeguarding Vulnerable Adults Network met in October 2011. The meeting focussed on financial abuse with a presentation on detecting and preventing financial abuse of older adults based on research undertaken by the Brunel Institute for Ageing Studies and another on detecting and preventing financial abuse of older adults by Kent Police. An update on the development of the Medway Local Community Network was given by Medway Council. The presentations from the Network Meeting can be found at: http://www.kent.gov.uk/adult_social_services/social_services_professionals/service_information/adult_protection/documents_library/presentations.aspx

Another Network Conference is planned for April 2012 with a focus on engaging service users and carers in adult safeguarding.

The Policy, Protocols and Guidance Review Group met in May and November 2011 to update the Kent and Medway multi-agency adult protection policy. The policy can be found at: https://shareweb.kent.gov.uk/Documents/adult-Social-Services/adult-protection/adult-protection-policies-protocols-and-guidance.pdf

In 2011 the multi-agency safeguarding leaflets were reviewed and following consultation with partner agencies, users and carers were combined into one single leaflet. The leaflet was launched at the Network meeting in October 2011. The leaflet can be found at: https://shareweb.kent.gov.uk/Documents/adult-Social-Services/leaflets-and-brochures/AdultAbuseLeaflet.pdf

Shout Out, an advocacy group in Medway, is developing an easy read version of the new leaflet, which will be launched in Autumn 2012.

Raising awareness of safeguarding vulnerable adults was the aim of a range of activities that took place during Safeguarding Week in June 2011. Partner agencies worked together across Kent and Medway with exhibitions in shopping centres, libraries, hospitals and supermarkets. Work is underway organising similar activities for Safeguarding Week in June 2012.

5 Kent and Medway Multi-agency Training

During 2011 - 2012 the multi-agency training programme has been supported by the Kent and Medway Safeguarding Vulnerable Adults Executive Board. This has been provided for through the funding of the following posts – one full time multi-agency Training Consultant and one full time multi-agency Training Administrator.

The training strategy continues to equip agencies to take responsibility for the delivery of adult protection awareness training to staff in their organisations. Awareness training is mandatory in all statutory services. Awareness training for staff in the private and voluntary sector has been available either through KCC Families and Social Care Learning Resource Team or by access to a Train the Trainers course to enable that sector to take control for direct delivery of training. All other training is provided by the multi-agency funded Training Consultant. The Level 4 course has been provided in collaboration with specialist trainers within a partner agency.

Kent and Medway, in partnership with an e-learning provider, makes a customised adult protection awareness e-learning training package freely available to anyone working with vulnerable adults in Kent and Medway. Details of how to access this are available on the website: (http://www.kent.gov.uk/adult_social_services/social_services_professionals/service_information/adult_protection/training/e-learning_course.aspx).

The training programme's core structure continues to be based on common tasks reflected in the Kent and Medway multi-agency policy, protocols and guidance. It aims to ensure that staff build on their existing knowledge and skills by adopting a sequential learning approach. It is designed to reflect core and complimentary knowledge and skills within the multi-agency context of safeguarding work. The current training programme is differentiated into six levels and delivered to multi-agency groups. Details of the course aims and objectives are available on the website: http://www.kent.gov.uk/adult_social_services/social_services_professionals/service_information/adult_protection/training.aspx

The table below outlines the level of multi-agency course provision and attendance during April 2011 – March 2012.

2011 - 2012		
Level	**Number of Delegates Trained**	**Number of courses**
Level 2	172	15
Level 3	131	8
Level 4	49	3
Level 5	36	2
Level 6	18	1
Train the Trainer	31	2
Train the Trainer Recall day	39	1
Level 2 P & V	41	4

Additionally the multi-agency Training Consultant has responded to requests for bespoke single agency training as detailed below:-

- 12 x half day Good practice in risk assessment in SVA for KCC, Families and Social Care

Training review and implementation plan

Recommendations from the training review undertaken in late 2010 were taken to the Executive Board for approval in March 2011. The Executive Board made a number of decisions following the review with the implementation plan being passed to the Executive Team for action. For a number of reasons delays have occurred in achieving this plan. A progress report was presented to the Executive Board in January 2012. The Executive Board agreed the following actions:

- The provision of the current Level 2 multi-agency training course will cease to be delivered within the multi-agency training programme
- The Level 2 training materials are subject to copyright and will be made available under agreement, for use by all agencies working with vulnerable people in Kent and Medway
- Suggested training standards for Level 2 will be available for any agency who prefers to commission or deliver it's own version of the current Level 2 course
- The multi-agency training programme will be limited to Levels 3, 4, 5 and 6
- Course places will be reserved proportionate to partner contributions to the budget to maximise a fair distribution of available places
- The Train the Trainer in Adult Protection awareness programme will no longer be delivered
- The e-learning package for adult protection awareness training will be updated to ensure that a premium product is available to all in Kent and Medway
- Non attendance and late cancellation fees for all courses will be introduced from April 2012
- Three pilot Train the Trainer in service user awareness of adult abuse courses will be commissioned in 2012 – 2013

Ongoing Developments

A multi-agency competency framework for all practitioners with responsibilities for safeguarding vulnerable adults remains in a draft format and is yet to be fully adopted. KCC Families and Social Care has piloted an assessment tool to be used in conjunction with the current competency framework document.

Work with a Higher Education Institute to gain academic accreditation of the training programme and thereby enable practitioners across all disciplines to gain recognition of the learning they have undertaken was suspended during the training review.

6 Funding Arrangements

The Kent and Medway Safeguarding Vulnerable Adults Executive Board is funded by 6 partner agencies including KCC Families and Social Care, Medway Council, Kent Police, NHS West Kent, NHS Medway and NHS Eastern and Coastal Kent. Each of these agencies makes the following percentage contributions:

KCC, FSC	33.2%
Medway Council	8.3%
Kent Police	22.5%.

The three health trusts contribute a total of 36% with the following breakdown:

NHS West Kent	13.5%
NHS Medway	5.7%
NHS Eastern and Coastal Kent	16.8%.

The multi-agency budget covers the salaries and expenses for the Safeguarding Adults Board Manager, Training Consultant and Administration Officer posts. It also covers the administration costs for the various multi-agency group meetings, Serious Case Reviews and resources for Safeguarding Week.

With NHS Kent and Medway ceasing to exist after March 2013 and Clinical Commissioning Groups being fully operational from April 2013 along with changes to the governance arrangements as a result of the governance review, consideration is being given to the funding arrangements from April 2013.

The table below sets out the budget contributions for 2011-2012 and 2012-2013.

The 3 NHS contributions are % of their 36% contribution to the total budget. In the chart below this is far from clear.

	2011 - 2012 Contribution requested (based on historic %'s) (£000's)	**2011 - 2012 Actual contribution (£000's)**	**2011 - 2012 Difference (£000's)**	**2012 - 2013 Contribution requested** (based on historic %'s) (£000's)	**2012 - 2013 Actual contribution** (£000's)	**2012 - 2013 Difference** (£000's)
KCC	59.7	59.7	0.0	63.1	63.1	0.0
Medway Council	14.9	14.9	0.0	15.8	15.8	0.0
NHS West Kent	24.3	24.3	0.0	25.7	25.7	0.0
NHS Medway	10.2	10.2	0.0	10.8	10.8	0.0
NHS Eastern and Coastal Kent	30.4	30.4	0.0	31.9	31.9	0.0
Kent Police	26.0	23.0	3.0*	28.5	22.9	5.6**
Total	165.5	162.5	3.0	175.8	170.2	5.6

* The shortfall is due to Kent Police not contributing to the Board Manager post.
** The shortfall is due to Kent Police not contributing to the Board Manager post and reducing their % contribution by 2.9%.

7 Partner Highlights

KENT COUNTY COUNCIL (KCC), FAMILIES AND SOCIAL CARE (FSC)

Overview of 2011 - 2012

This year the central Safeguarding Adults Unit has been developed within Strategic Commissioning. The unit supports the functions of safeguarding through policy implementation, practice guidance and monitoring in adult protection, mental capacity and the deprivation of liberty safeguards. The unit ensures there are clear governance arrangements in place to enable senior managers and Members to be fully informed of issues related to safeguarding. This includes monitoring action plans developed following Serious Case Reviews and Domestic Homicide Reviews.

Key Achievements

- Using the LEAN process, the adult protection alert/referral form was reviewed. The new alert form, the SG1, includes audit checks and risk assessment and was launched in February 2012. It has been welcomed by practitioners.
- The Quality in Care Framework was implemented to assist in dealing with quality and practice issues within services.
- A programme of internal and external case audits demonstrates an ongoing improvement in case work and recording.

Key Challenges

- Adult safeguarding specialists joined the Central Duty Team with Children's Services on 28 March 2012. The aim is to ensure greater consistency in addressing the initial stages of adult protection alerts. This service brings together Police, Social Services and Health representatives to address adult and child protection and domestic abuse.
- The Safeguarding Adults Competency Framework implemented in February 2011 and is being reviewed.
- To improve information recording, ensure cases are closed appropriately and target preventative activity effectively.

Future Plans 2012 - 2013

- Essex County Council will Peer Review Kent's safeguarding arrangements.
- To continue to implement a programme of internal and external audit.
- To use our feedback tool to enable users to provide feedback on adult protection work and to improve our responses.
- The function of the safeguarding adults unit will be reviewed.
- To monitor action plans from domestic homicide and serious case reviews.
- To continue the risk strategy meetings with the Care Quality Commission.
- To complete a safeguarding training needs analysis for the Directorate.
- The Families and Social Care Countywide Safeguarding Board will develop its safeguarding action plan.
- The provider training survey will be completed to evidence uptake of safeguarding and MCA training.
- Implementation of Central Referral Unit.
- To plan for Safeguarding Awareness Week June 2012, increasing public awareness of safeguarding.

7 Partner Highlights

MEDWAY COUNCIL

Overview of 2011 – 2012

Medway Council has continued its development plans by ensuring that it builds on the learning from our independent review of safeguarding arrangements conducted in 2011. The formation of the Medway Local Network has been valuable in ensuring that partners across Medway are able to share best practice and find local solutions that support partnership working.

Key Achievements

- Medway's Local Network meetings have commenced.
- Appointment of a Safeguarding Co-ordinator to support best practice in recording and documentation.
- Robust multi-agency training plan – including delivery of training to local neighbourhood police officers, commencement of joint Level 2 training with Medway Community Healthcare and supporting partners in delivering an awareness day for practice leads and general practitioners across Kent and Medway.

Key Challenges

- Following an adult protection referral, we ensure that alleged victims are kept informed and their wishes are heard throughout the process.
- Increasing public awareness, particularly amongst ethnic minority groups.
- Robust and safe adult protection case work that can demonstrate the protection of service users.

Future Plans 2012 – 2013

- In order to strengthen the safeguarding principle of empowerment we will be commencing Family Group Conferences to support victims and their families following allegations of abuse.
- Developing designated senior officer roles through a training programme, which includes chairing skills and risk assessment in adult protection.
- Developing and supporting our administration staff to ensure that our adult protection meetings are recorded in an accurate and timely fashion.
- Introduction of performance indicators to measure referral activity against agreed protocol timescales.
- Integrate our awareness training with the private and voluntary sector training programme.

KENT POLICE

Overview of 2011 - 2012

In order to maintain Police performance in the face of a considerable cut in budget, it was necessary for Kent Police to make significant alterations to the structure of the force. This has meant a reduction from six Policing areas to three divisions.

Public Protection Units were not immune to the changes. In October 2011 all officers and staff working in Public Protection (Child abuse, adult abuse, domestic abuse and the management of sex offenders) ceased to be part of an area crime group and were brought under the management of Headquarters Public Protection. With a reduction in the number of officers and staff it was necessary to build resilience into the functions of each strand. Consequently those officers that were formerly child abuse investigators, adult abuse investigators and domestic abuse officers became 'Combined Safeguarding' Officers able to deal with each of the three incidents/investigations/victims. A further change was aligning safeguarding teams to Children's Social Services boundaries, rather than Kent Police divisions.

As far as Adult Protection is concerned this increased our workforce from one or two district contacts to a pool of investigators with specialist knowledge of child abuse and domestic abuse. This is extremely beneficial given the links between the three strands under increased supervision at seven bases.

Key Achievements

- Re-structure of Public Protection Units.
- Implementation of Central Referral Unit.
- Maintaining performance despite changes.

A fundamental part of the restructure was the launch of the Central Referral Unit in January 2012. This represents a radical change in the way Police and partners conduct safeguarding business. Initially launched by co-locating Police and Children's Social Services in order to manage all strategy discussions, it is evolving and now has Adult Social Care, health and education involved. It is hoped that this will not only provide a consistent response across the County but also improve multi-agency working, by co-location and improved awareness of cross-organisation capability and skills base.

We cannot be complacent, but such improvements are already bringing a more consistent response. A review of formal structure and safeguarding adult protocols is underway. It is vital that lessons learnt from other safeguarding strands are at the centre of the review.

Future plans for 2012 - 2013

- Fully embedding Adult Protection into the Central Referral Unit.
- Training all PPU officers in Adult Abuse Investigation.
- Ensuring the workforce are fully informed and involved in identifying and safeguarding vulnerable adults.

7 Partner Highlights

NHS KENT AND MEDWAY

Overview of 2011 - 2012

In June 2011, the three Primary Care Trusts (PCT) (NHS Eastern and Coastal Kent, NHS Medway and NHS West Kent) formally clustered to create NHS Kent and Medway. Adult safeguarding leads across the three PCTs came together in one safeguarding team within the Nursing and Quality Directorate, and led by the Associate Director of Safeguarding. The PCT safeguarding team have continued to work closely with health providers and statutory partners to improve outcomes for vulnerable adults.

All health care organisations across Kent and Medway have a responsibility to ensure that the people they provide care to are safeguarded. They all have mechanisms to report safeguarding progress, issues and concerns through their governance structures to Board level.

Key achievements

- A specialist nurse for safeguarding in care homes was recruited in September 2011 and has been working in partnership across the care home sector to support multi-agency responses to incidents of abuse and poor quality care.
- The PCT also agreed additional funding for a Designated Nurse in Adult Safeguarding to cover the Medway locality and this was recruited to in February (due to commence at the end of May 2012).
- Increasing GP awareness of adult safeguarding through identification of practice safeguarding leads and targeted safeguarding awareness session held in March 2012.

Key challenges

- Responding to requests for assistance and support in investigating allegations of abuse in the care home sector, despite the recruitment of the specialist nurse. The post covers Kent and Medway and with the vast numbers of care homes and multiple sites of alleged abuse this has proved challenging.
- Maintaining safe services for vulnerable adults through the current NHS reforms and changes in providers, particularly where they have merged. In particular, increasing numbers of grade 3 and 4 pressure ulcers being reported from acute hospital and community settings.

Future plans for 2012 - 2013

- Seek further clarity about the transfer of adult safeguarding responsibilities and ensure that they are handed over to future commissioning bodies, including Clinical Commissioning Groups (CCGs) and the National Commissioning Board.
- Support the review of the Safeguarding Vulnerable Adults Board and liaise with CCGs and providers to secure appropriate representation.
- Encourage and support providers to increase adult safeguarding resources where performance suggests this is necessary, particularly in acute hospital settings.

DARTFORD AND GRAVESHAM NHS TRUST

Overview of 2011 – 2012

- Safeguarding training through core induction and mandatory training attendance achieved 100% and 91.5% respectively.
- KCC training dates for safeguarding and DOLS training conveyed to all relevant Trust staff groups.
- Training prospectus and Training Needs Analysis (TNA) achieved – first training session takes place on 24 May 2012.
- Safeguarding Lead continues her own relevant KCC safeguarding training.
- Maintenance of the Safeguarding Vulnerable Adults Dashboard for the PCT.
- Maintenance of Trust AP1 spreadsheet.
- Continued to audit quarterly the numbers and outcomes of safeguarding referrals.
- Attendance at case conferences by Trust Safeguarding Lead.

Key achievements

- Clinical Bands 6 – 8 trained in MCA/DOLS.
- A Training Needs Analysis was created to provide an overarching mandatory cognitive impairment training package. A review of the current provision of Learning Disability study days to relevant Trust staff led to the combined teaching within the new Cognitive Impairment study sessions, provision of a training prospectus (organised by clinical or non-clinical banding).
- MCA audit around consent and fractured neck of femur pathway documentation was undertaken and feedback is awaited from the orthopaedic Consultants.

Key challenges

- Ensuring capacity assessments are completed and documented.
- Ensuring completion of the correct consent form for people who lack capacity.
- Receipt of fully completed SG1 alert forms from ward staff.

Future plans in 2012 - 2013

- Working more closely with the Tissue Viability Nurse's (TVN) to continue the education of ward nurses around pressure ulcers as part of the Pressure Ulcer Training sessions/updates.
- Tissue Viability Nurse link nurse meeting - presentations around pressure sores and potential neglect.
- Training prospectus and TNA achieved – University of Greenwich provision of new cognitive impairment training for all staff involved in clinical settings covering the following items:
  - Differential diagnosis (Delirium, Depression or Dementia?)
  - Managing behaviour that challenges
  - Decision making, including MCA, Legal and Ethical considerations
  - Person-centred approaches to communication and behaviour

7 Partner Highlights

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST (EKHUFT)

Overview of 2011 - 2012

During 2011/12 the Safeguarding team have worked with senior matrons and matrons across each of the four divisions to support their role in being local champions for adult safeguarding. The Safeguarding Policy is in the process of being amended and updated to include any changes in legislation.

The Trust wide adult safeguarding group used the opportunity this year to review the functions of the group and identify ways to increase the profile and develop the functional delivery of adult safeguarding within the Trust. A wide range of issues were discussed, ranging from the management of dementia, falls and pressure ulcers to the work of improving patient pathways for people with learning disabilities. We have built on the positive relationship with our commissioners and have used the opportunity to identify areas of further development. The Group also has responsibility for reviewing adult safeguarding alerts and identifying key themes and trends in support of the divisional governance processes and ensuring there are sufficient systems in place to ensure we meet the two key domains of the NHS Outcomes Framework.

We currently report activity to NHS South of England and the Kent and Medway Adult Safeguarding Board. The South East Coast Strategic Health Authority introduced a new dashboard for adult safeguarding and we have submitted the Trust's activity on a monthly basis. The Urgent Care and Long Term Conditions Division has a standing adult safeguarding agenda item at its governance meetings with each of the other divisions having the opportunity to discuss specific adult safeguarding concerns through their appropriate governance groups. During 2011/12 there were 113 concerns raised and shared between health and social care partners. This relates to patients that have been admitted to hospital that we have concerns about. There have been 94 alerts raised about the potential risk of a vulnerable adult within our care. These alerts progress to an assessment of further investigation. The Trust provided adult safeguarding training to 576 members of staff through a mixture of face to face and e-learning. The Trust participated in gathering evidence for three domestic homicide reviews.

Key achievements

- Published the Patient Passport for people with learning disabilities.
- Developed a real time system for identifying learning disability inpatients so that we can proactively support frontline teams in delivering high quality care.
- Developed and published the policy for clinical restraint.

Key challenges in 2011 – 2012 / Future plans for 2012 - 2013

- Improve and extend access to guidance to MCA documents and forms on the Trust's intranet and enhance the profile of the MCA requirements across the Trust generally.
- Encourage the use of the 'best interest meeting' pro-forma developed by the Kent and Medway MCA Local Implementation Network to improve recording of the outcomes of best interest meetings.
- Increase awareness and training frequency for all staff in a variety of ways to suit learning styles and shift/ release arrangements.

MEDWAY NHS FOUNDATION TRUST

Overview of 2011 - 2012

Safeguarding activity has increased over 2011/12 with a sharp increase in the number of referrals for support with patients being detained under the Mental Health Act 1983 (MHA). The Hospital Psychiatric Liaison Team, now fully operational; support ward and departmental staff through advice, psychiatric assessments and behavioural management strategies.

The Trust continues to utilise Deprivation of Liberty Safeguards to protect the rights of incapacitated patients, with clinical staff identifying those at risk in a timely manner. However, our patients usually only require urgent authorisations owing to the nature of their presenting condition.

A new Learning Disability Liaison Nurse will be taking up their post in November 2011. The role is operational with the nurse providing daily support for both patients and staff. The Nurse acts as a single point of contact for families and community teams to facilitate the admission and discharge of people with a learning disability that require reasonable adjustments to access healthcare.

Safeguarding training compliance has remained above 85% this year and Mental Capacity Act (MCA) compliance has remained above 90%. Trust policies relating to safeguarding have been reviewed to reflect changes to practice and national guidance.

Key achievements

- Meeting the needs of patients with a severe learning / behavioural disability in a single, planned admission - multiple specialities were able to provide treatment, investigations and health screening.
- Collaborative working with the Mental Health Liaison Service to help staff understand and use the MHA appropriately to detain patients on a general ward.
- The MCA Compliance audit by South Coast Audit evidenced good practice within the Trust.

Key challenges

- Inappropriate use of safeguarding process to address transfer of care issues.
- Supporting clinical staff to use restraint appropriately to deliver care and treatment within the context of best interests.
- Supporting staff to differentiate between the use of the MHA and the MCA.

Future plans for 2012 - 2013

- Supporting clinical staff to perform capacity assessments confidently and further developing confidence to use the best interest decision making framework in practice.
- Working collaboratively with local Acute Trusts to develop a Level 2 safeguarding training programme and meeting the needs of acute health staff whilst maximising time/skill resources in its delivery
- Rolling out PREVENT* training to appropriately identified staff to manage the risk posed by this year's national and international events.

*PREVENT
This strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the Government's counter-terrorism strategy, CONTEST.

7 Partner Highlights

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Overview of 2011 – 2012

Our Safeguarding Adults Policy has been reviewed and updated to include more information on Domestic Abuse and associated tools and training, PREVENT and associated referral mechanisms, links to the Trust's Route Cause Analysis and Serious Incident Requiring Investigation (SIRI) for Pressure Ulcers.

The role of the Safeguarding Champions across the Trust has been reviewed, adding the role of Dementia Champion into this. Safeguarding Resource Folders are in place in each clinical area and have been updated to include information relating to Dementia.

Work continues to ensure that the training strategy with regards to Safeguarding Adults, Mental Capacity Act and Deprivation of Liberty Safeguards meets the requirements of staff to ensure appropriate responses and referrals are made on behalf of patients. Trust staff are 88.8% compliant with ensuring they attend safeguarding training to update their knowledge and skills.

Trusts representatives are active in the multi-agency local and regional meetings. The Trust celebrated both the Dignity Action Day 25.02.2011 and the Safeguarding Adults Awareness week in June 2011.

The Trust has identified the Matron for SVA as the lead for ensuring the Government's PREVENT agenda is publicised and adhered to by practitioners.

Key Achievements

- The Matron for SVA (or delegate) sits on the Trust's Pressure Ulcer Serious Incident Requiring Investigation Panel.
- Further development of the Safeguarding Champions Role to include Dementia.
- Identification and agreement of the Trusts PREVENT Lead.

Key Challenges

- Review and updating of discharge processes to ensure the ongoing safety of patients when leaving hospital care and that documentation is clear and robust.
- Continued embedding of MCA processes and ensuring that Mental Capacity Assessments are undertaken and reviewed appropriately.
- Ensuring that Domestic Violence training is undertaken by identified staff and promoting the use of the DASH Tool where appropriate.

Future Plans for 2012 – 2013

- Gain agreement from the Adult Safeguarding Executive Board in relation to expected content and delivery of Level 2 SVA Training.
- Purchase identified restraint training to ensure that staff have confidence when having to restrain patients in line with the MCA and DoLs.

MEDWAY COMMUNITY HEALTHCARE

Overview of 2011 - 2012

Within Medway Community Healthcare the Safeguarding Adults Team has continued to build upon previous developments in training and clinical supervision with frontline staff. This has included the creation of multi-agency Level 2 Safeguarding Adults training with Medway Council and the inclusion of the PREVENT strategy in all levels of in-house training.

The team continues to encourage and support staff in raising Safeguarding Adults concerns including alerts, capacity assessments and Deprivation of Liberty Safeguards Applications.

In order to meet the reporting requirements of both the Strategic Health Authority and Care Quality Commission a new database has been developed.

Staff appear to have an increased awareness and confidence in raising issues they believe may be a safeguarding adults concern. This is evidenced by the quality and quantity of enquiries the team receives.

Key Achievements

- Increase in numbers of referrals from front line staff.
- Good attendance at training and engagement in supervision.
- Positive feedback from new Level 2 multi-agency Safeguarding Adults training.
- Greater engagement in the domestic abuse agenda.
- Involvement in the Medway Safeguarding Adults Awareness Week events for the general public and multi-agency professionals.
- Development of database to enable reporting requirements.

Key Challenges

- To ensure accurate and adequate documentation of all safeguarding adults issues, including actions to safeguard, capacity assessments and best interest decisions.
- To raise awareness of domestic abuse with staff in adult services, as well as children's.
- To equip services with skills and knowledge to provide and facilitate clinical supervision in-house.

Future Plans for 2012 - 2013

- Develop Level 1 training to cover all aspects of Safeguarding Adults practice including Mental Capacity Act, Domestic Abuse and PREVENT.
- Working alongside the development of a new IT system to facilitate the accurate and timely documentation and reporting of Safeguarding Adults concerns.
- To work collaboratively with the local Safeguarding Adults network to improve public engagement and feedback.

7 Partner Highlights

KENT COMMUNITY HEALTH NHS TRUST

Overview of 2011 – 2012

Safeguarding practice is assured through self assessments against CQC standards which are then validated at 'challenge' meetings, executive team weekly safety walkabouts, and a rolling programme of unannounced children and vulnerable adults safeguarding compliance visits to be introduced in 2012/13.

We updated our Adult Protection policy to reflect changes in local and national guidance and introduced new organisation-wide policies that impact upon safeguarding, to further embed safeguarding practice into frontline care, in particular Mental Capacity Act (MCA) assessment forms, Consent, Restraint and Incident Reporting policies. A number of Trust operational policies, guidelines and protocols, that support the overarching safeguarding agenda have also been reviewed, including Wound Management and Transfer of Care.

We reviewed how we deliver our safeguarding training, including developing pre-course workbooks to support our MCA basic awareness and Consent workshops.

Key achievements

- There are more robust processes in place which have led to safeguarding being incorporated in the review of complaints, serious incidents and other incidents. The lessons learnt that relate to safeguarding are managed through the organisation's governance structures.
- Safeguarding awareness has improved within services and reporting data evidences the increase in reporting. Outcomes from safeguarding concerns raised within the organisation have led to the development of an Out of Hours protocol for staff, to support them accessing safeguarding advice and guidance during these times.
- Investigation learning has improved clinical practice, e.g. shared care protocols, team reviews, new handover systems.
- Improved uptake of SVA training from 19% to 72%.

Key challenges

- Staff understanding the interdependency of the various strands of adult safeguarding, e.g. consent, restraint and capacity alongside clinical staff in the provision of supervision, support and advice.
- Review of existing safeguarding resources to identify additional capacity to support the organisation's safeguarding vulnerable adults and mental capacity agenda.
- Improving the awareness and application of MCA/DoLs to frontline practice/decision-making – the current position for KCHT very much reflects the national issues identified by CQC in their overview of how the Safeguards were implemented and used in 2010/11 (The operation of DoLs in England, 2010/11, March 2012).

Future plans for 2012 - 2013

- Gaining a common understanding of adult thresholds across the partnership, including a reduction in the number of re-referrals to social care.
- Reducing the number of cases of adult neglect attributed to KCHT.
- Ultimately, no reported cases of adult neglect attributed to KCHT.
- Achieve 95% compliance for SVA training.

KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST (KMPT)

Overview of 2011 - 2012

This year there has been a real focus on the quality and standards of safeguarding practice driven by the Adult Safeguarding Improvement Plan. KMPT has participated in 6 monthly external audits of case files and each result has shown improvement in standards of practice.

We have supported staff through training and supervision. The supervision policy was reviewed to ensure it was robust and fit for purpose on matters of safeguarding. There was additional support from 1 WTE safeguarding co-ordinator for the Access and Recovery teams dealing with the bulk of the safeguarding processes within KMPT.

With Deprivation of Liberty assessments we have been timely in their completion and this is due to the commitment of the consultants participating in the process and the administrative support within the team.

Key achievements

- We have expanded the safeguarding team and now have a lead for domestic abuse and a Domestic Abuse Strategy to give a framework to the work of the Domestic Abuse Lead.
- The Trust wide Safeguarding Group has recommenced and is chaired by the Executive Safeguarding Lead.
- The monitoring of adult protection alerts and provision of monthly figures to the service lines is possible through a database held within the safeguarding team.

Key challenges

- Ensuring safeguarding cases do not drift has been a challenge and extra guidance was put in place by the safeguarding team to try and address this issue.
- Bringing Level 2 safeguarding training in-house challenges the resource and capacity within the safeguarding team.
- Having only 1 PREVENT trainer is also a challenge within an organisation that has over 3000 staff.

Future Plans for 2012 - 2013

- With support from the Safeguarding co-ordinators we aim to get safeguarding cases to a level considered good or above when evaluated.
- To reduce the numbers of safeguarding cases open longer than 6 months.
- Roll out of domestic abuse workshops for staff across the organisation.
- Training remains a priority as we aim to reach 95% compliance on all levels of safeguarding training.
- Audits will be conducted to determine staff understanding of Mental Capacity assessment in ward areas and community teams.

7 Partner Highlights

SOUTH EAST AMBULANCE NHS FOUNDATION TRUST (SECAMB)

SECAmb covers Surrey, Sussex, Kent and a small part of Hampshire. The Trust has a full time safeguarding lead for adults and children and is committed to the multi-agency safeguarding process and this is reflected in the policies and procedures adopted by the Trust.

Overview of 2011 - 2012

During the year 1st April 2011 – 31st March 2012 SECAmb staff submitted 2493 adult concern reports for the whole region. The majority of these were connected with social care concerns, particularly regarding living conditions and patient's inability to cope alone or with increasing care needs. The number of reports received regarding adults specific to the Kent and Medway area was 650, and when broken down the distribution is:

- Kent – 550 referrals (22.1% of all SECAmb referrals)
- Medway – 100 referrals (4% of all SECAmb referrals)

Outcomes are known for 14 cases in the Kent area and 3 in Medway.

Key achievements

- Reporting rates have continued to rise with an increase of 68.59% on the previous year which suggests an increased awareness of adult social care needs amongst our operational staff.
- Foundation work has been undertaken to establish links with local MARACs and a direct reporting route from SECAmb into these is being developed; a substantial piece of work around the DASH (domestic abuse) toolkit having been completed to date.
- Robust links with the Trust's Compliance team has led to improved collaborative working around serious incidents where Safeguarding elements exist and how they are managed and investigated within the Trust.

Key challenges

- Getting consistent outcomes for reports from health and social care departments across all geographical locations.
- Staff training was challenging although staff did undertake some e-learning modules and all new staff undergo corporate induction which has an introduction to safeguarding element.
- Consistent implementation of the Mental Capacity Act including interaction and understanding of roles and responsibilities when working with other agencies.

Future Plans for 2012 - 2013

- A robust training needs analysis has been undertaken and a comprehensive four year training plan has been developed; training is now being implemented.
- Work is underway to identify frequent callers and develop greater multi-agency management of cases identified following a serious case review recommendation.
- Other developments include an outcomes database to map recommendations from all reviews, MOUs* with police in regard to application of MCA, implementation of a DASH toolkit for all SECAmb staff and referral pathways into the MARAC** process and complete revision of Consent and Capacity procedures.

*Memorandum of understanding / **Multi-Agency Risk Assessment Conference

8 Safeguarding Activity

8.1 Background to the data

The data for this report was extracted from Kent County Council's social care system (SWIFT) and Medway Council's safeguarding database. In most cases, the data included in this report are consistent with the Abuse of Vulnerable Adults (AVA) DH statutory return (latest AVA submitted in June 2012 - data subject to validation).

The first section summarises new safeguarding referrals. A safeguarding referral is where a concern has been raised invoking an adult safeguarding investigation or assessment. In Kent, cases that do not meet the safeguarding threshold are not fully investigated and therefore are not included within this section. In Medway, all safeguarding alerts raised are investigated fully as referrals and the numbers are included in the numbers here. The second section summarises the outcome for closed referrals.

8.2 New Adult Protection Referrals

8.2.1 Number of Referrals and Rate of Change

During 2011- 2012, there were 2,756 new referrals across Kent and Medway. This is an increase of 17.3% on 2010 - 2011. East Kent contributed the majority with 1,560 (56.7%) of all referrals. This is an increase of 23% on 2010 - 2011. West Kent, which contributed 781 (28.3%) of all referrals, showed a smaller increase of 3.2% on 2010 - 2011. Medway contributed 15.1% with 415 referrals, an increase of 28.1% on 2010 - 2011. This increase can demonstrate an increase in public awareness.

Area	2009-2010	2010-2011	2011-2012	% change between 2010-2011 and 2011-2012	% of total in 2011-2012
East Kent	1,341	1,268	1,560	23.0%	56.7%
West Kent	793	757	781	3.2%	28.3%
Medway	277	324	415	28.1%	15.1%
All	**2,411**	**2,349**	**2,756**	**54.3%**	**100.0%**

Table 8.2.1: Safeguarding Referrals across Kent and Medway for the periods 2009-2010 to 2011-2012

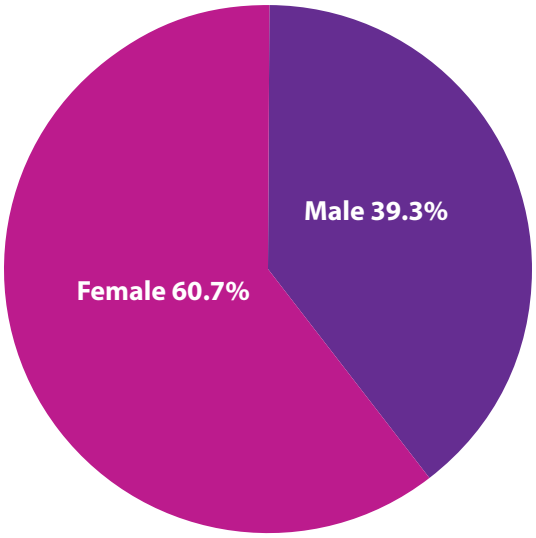
8.2.2 Gender of Alleged Victims

In 2011 - 2012, 39.3% of alleged victims were male and 60.7% were female. There has not been a significant change in the gender breakdown of alleged victims over the last three reporting periods.

Gender	2009-2010		2010-2011		2011-2012	
	number	%	number	%	number	%
Male	883	36.6%	866	36.9%	1,083	39.3%
Female	1,527	63.3%	1,483	63.1%	1,673	60.7%
Unknown	1	0.0%	0	0.0%	0	0.0%
Total	**2,411**	**100.0%**	**2349**	**100.0%**	**2,756**	**100.0%**

Table 8.2.2: Gender breakdown across Kent and Medway of alleged victims for the periods 2009-2010 to 2011-2012

Figure 8.2.2: Gender breakdown of alleged victims 2011/12



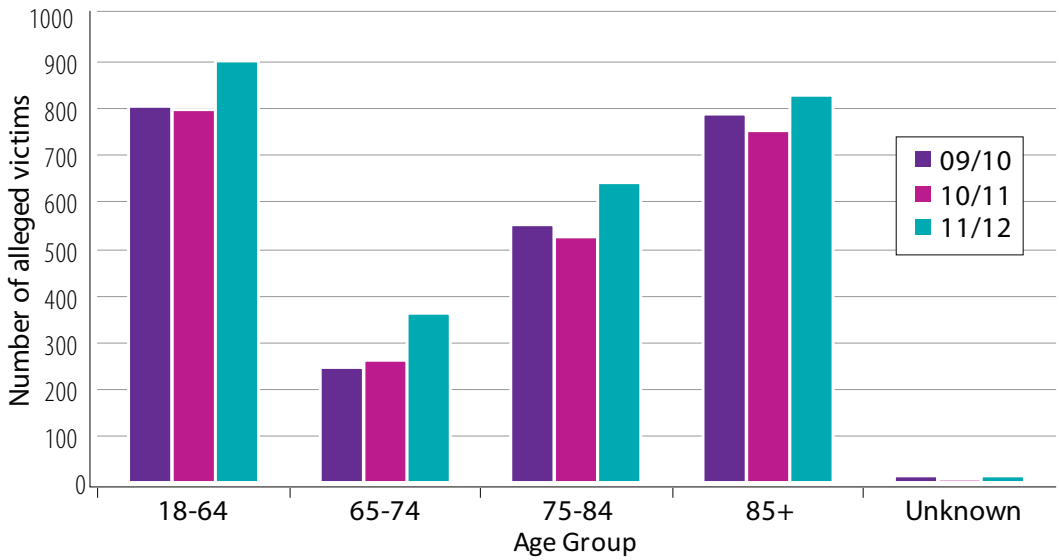
8.2.3 Age Group of Alleged Victims

In 2011 - 2012, approximately one third of alleged victims were aged 18-64 and two thirds were aged 65+. There has not been a significant change in the age breakdown of alleged victims over the last three reporting periods.

Age Group	2009-2010		2010-2011		2011-2012	
	number	%	number	%	number	%
18-64	806	33.4%	799	34.0%	906	32.9%
65-74	245	10.2%	266	11.3%	364	13.2%
75-84	553	22.9%	525	22.3%	645	23.4%
85+	793	32.9%	754	32.1%	831	30.2%
Unknown	14	0.6%	5	0.2%	10	0.4%
Total	**2,411**	**100.0%**	**2,349**	**100.0%**	**2,756**	**100.0%**

Table 8.2.3: Age breakdown across Kent and Medway of alleged victims for the periods 2009-2010 to 2011-2012

Figure 8.2.3: Age breakdown of alleged victims from 2009/10 to 2011/12



8 Safeguarding Activity

8.2.4 Ethnic Group of Alleged Victims

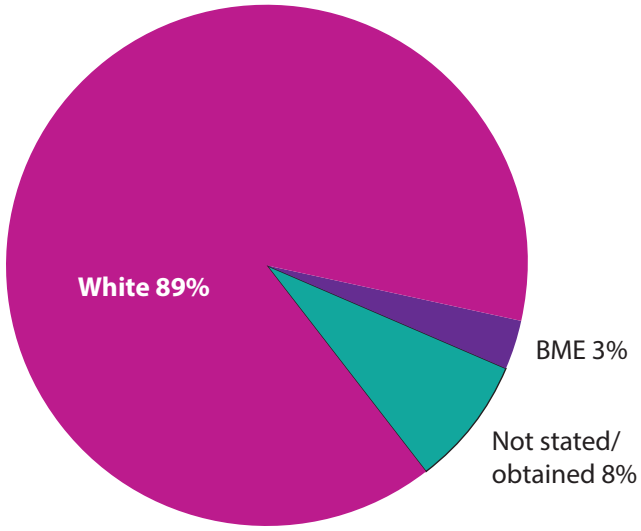
In 2011 - 2012, 3.1% of alleged victims were from black or minority ethnic groups, a slight increase on 2010 - 2011 but consistent with 2009 - 2010. There has been an increase in the proportion of alleged victims where ethnicity was not stated or the information not obtained. In the KCC area 7.6% of the population were of Black Minority Ethnic (BME) origin as at 2009.

Ethnic Group	2009-2010		2010-2011		2011-2012	
	number	%	number	%	number	%
White *	2,188	90.8%	2,137	91.0%	2,445	88.7%
BME **	76	3.2%	52	2.2%	85	3.1%
Not stated / Not obtained	147	6.1%	160	6.8%	226	8.2%

Table 8.2.4: Ethnic Group breakdown across Kent and Medway of alleged victims for the periods 2009-2010 to 2011-2012

** 'White' contains the DH ethnic groups of White British, White Irish, Traveller of Irish Heritage, Gypsy/Roma, Other White Background.*
*** 'BME' includes all Asian or Asian British, Black or Black British, Mixed and Other groups.*

Figure 8.2.4: Ethnic breakdown of alleged victims 2011/12



8.2.5 Client Category of Alleged Victims

The table below shows the proportions of each client category against age group for the last three reporting periods. In the 18-64 age group, the majority of alleged victims had a primary client category of Learning Disability, with 15.6% of all alleged victims in this category. This is a slight decrease when compared to the previous two periods. The proportion of clients aged 18-64 with a primary client category of Mental Health has increased from 3.6% in the last two periods to 6.3% in 2011 - 2012. The increase in the Mental Health category in Medway can be attributed to improved recording.

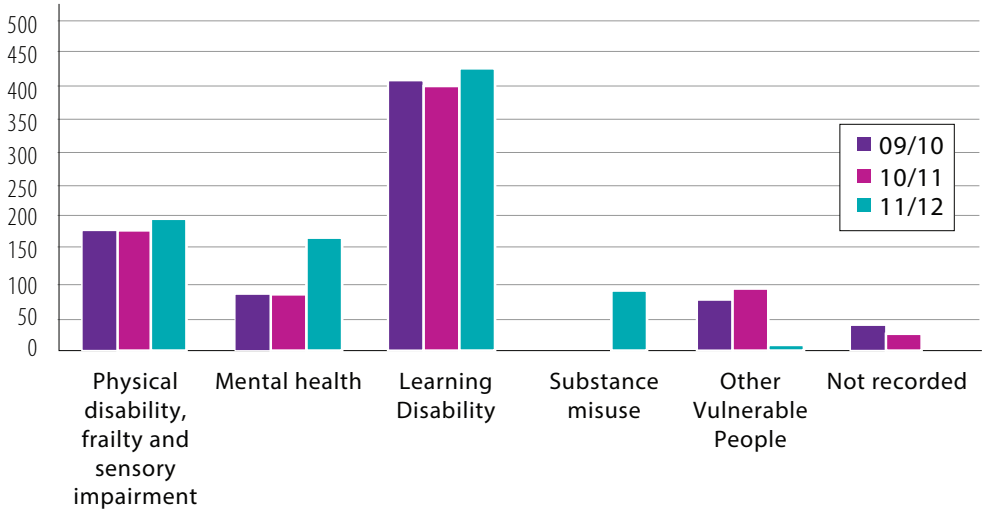
The proportion of alleged victims aged 65+ with a primary category of Mental Health has also increased, from 11.1% in 2010 - 2011 to 13.8% in 2011 - 2012.

Primary Client Category	2009-2010		2010-2011		2011-2012	
	18-64	65+	18-64	65+	18-64	65+
Physical disability, frailty and sensory impairment	7.8%	44.1%	8.0%	46.1%	7.4%	46.3%
Mental Health	3.6%	10.6%	3.6%	11.1%	6.3%	13.8%
Learning Disability	17.2%	1.1%	17.2%	1.7%	15.6%	1.6%
Substance misuse	0.1%	0.1%	0.1%	0.0%	0.2%	0.0%
Other Vulnerable People	3.3%	5.8%	4.1%	4.6%	3.3%	5.1%
Not Recorded	1.7%	4.7%	1.1%	2.5%	0.0%	0.0%

Table 8.2.5: Primary Client Category breakdown across Kent and Medway of alleged victims for the periods 2009-2010 to 2011-2012

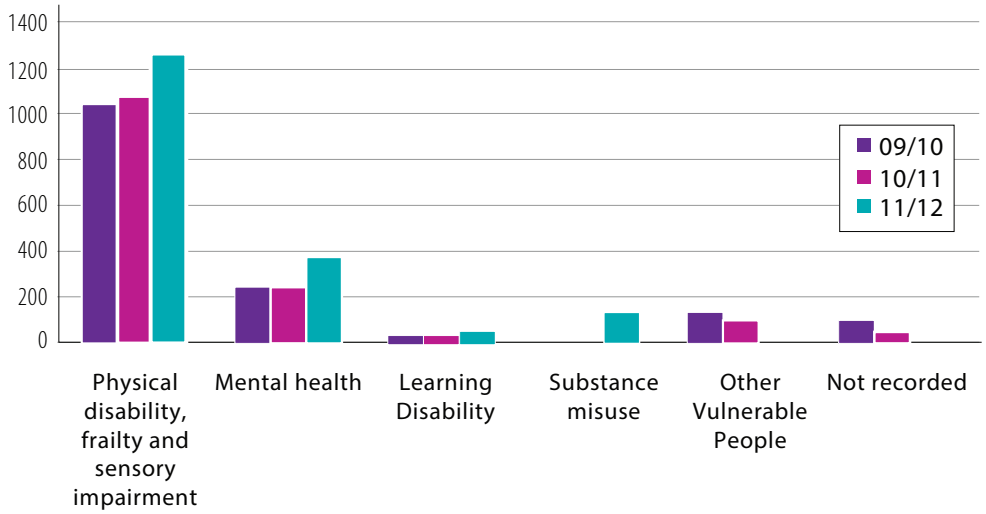
(A small number of alleged clients with an unknown age group have been excluded from this table)

Client Category of Alleged Victims 18-64



8 Safeguarding Activity

Client Category of Alleged Victims 18-64



8.2.6 Source of Safeguarding Referrals

The source of safeguarding referrals is shown below. Source categories correspond to the AVA return. Social Care Staff continue to contribute to over one third of referrals with a slight increase in proportion of all referrals year on year. The proportion of referrals from Health Staff has also increased and now contributes to one quarter of referrals, indicating an increase in awareness amongst health staff.

Source of Referral	2009-2010		2010-2011		2011-2012		% change between 2010-2011 and
	number	%	number	%	number	%	
Social Care Staff	883	36.6%	865	36.8%	1039	37.7%	20.1%
Health Staff	457	19.0%	539	22.9%	696	25.3%	29.1%
Self Referral	91	3.8%	88	3.7%	82	3.0%	-6.8%
Family member	201	8.3%	236	10.0%	271	9.8%	14.8%
Friend/neighbour	77	3.2%	56	2.4%	42	1.5%	-25.0%
Other service user	4	0.2%	2	0.1%	4	0.1%	100.0%
Care Quality	56	2.3%	23	1.0%	69	2.5%	200.0%
Housing	69	2.9%	46	2.0%	48	1.7%	4.3%
Education/Training/	12	0.5%	12	0.5%	9	0.3%	-25.0%
Police	109	4.5%	145	6.2%	162	5.9%	11.7%
Other*	373	15.5%	302	12.9%	334	12.1%	10.6%
Unknown	79	3.3%	35	1.5%	0	0.0%	-100.0%
Total	**2411**	**100.0%**	**2349**	**100.0%**	**2756**		**17.3%**

Table 8.2.6: Source of referral breakdown across Kent and Medway of alleged victims for the periods 2009-2010 to 2011-2012

**Other includes source category of Other, Anonymous, Informal Carer, Legal Agency*

8.2.7 Location of Abuse

In 2011 - 2012, 41.3% of referrals involved alleged abuse in a Residential Care Home - this is a slight increase on 2010 - 2011 but remains consistent over the three reporting periods. 35.2% of referrals involved abuse in the clients own home - this is a decrease on the previous two reporting periods. The proportion of referrals where the location of abuse was not known has increased year on year from 2.4% in 2009 - 2010 to 7.2% in 2011 - 2012.

Location of alleged abuse	2009-2010		2010-2011		2011-2012		% change between 2010-
	number	%	number	%	number	%	
Residential Care Home *	1064	44.1%	912	38.8%	1139	41.3%	24.9%
Own Home	904	37.5%	973	41.4%	969	35.2%	-0.4%
Supported Accommodation	113	4.7%	82	3.5%	109	4.0%	32.9%
Hospital / Other Health Setting **	77	3.2%	79	3.4%	96	3.5%	21.5%
Other ***	93	3.9%	61	2.6%	103	3.7%	68.9%
Public Place	42	1.7%	47	2.0%	66	2.4%	40.4%
Day Centre/ Service	24	1.0%	42	1.8%	37	1.3%	-11.9%
Alleged Perpetrators Home	22	0.9%	38	1.6%	31	1.1%	-18.4%
Mental Health Inpatient Setting	2	0.1%	1	0.0%	7	0.3%	600.0%
Education/ Training/ Workplace	13	0.5%	9	0.4%	0	0.0%	-100.0%
Not Known	57	2.4%	105	4.5%	199	7.2%	89.5%
Total	**2411**	**100.0%**	**2349**	**100.0%**	**2756**	**100.0%**	**17.3%**

Table 8 2.7a: Location of alleged abuse across Kent and Medway for the periods 2009-2010 to 2011-2012
** All care home settings, including nursing care, permanent and temporary*
*** Acute, community hospitals and other health settings*

Table 8.2.7b gives a breakdown of alleged abuse in residential care homes by area. East Kent had the highest proportion of referrals involving abuse in a residential care home setting with 47.1%, consistently higher than the other areas. In West Kent 32.9% of referrals involved alleged abuse in a residential care home setting, a decrease year on year from 2009 - 2010. West Kent had the lowest proportion of referrals where the alleged abuse took place in a residential care home setting with 33.0% but shows a slight increase year on year.

Area	2009-2010		2010-2011		2011-2012	
	number	%	number	%	number	%
East Kent	636	47.4%	547	43.1%	730	46.8%
West Kent	349	44.0%	267	35.3%	258	33.0%
Medway	79	28.5%	98	30.3%	151	36.4%
All	**1064**	**44.1%**	**912**	**38.8%**	**1139**	**41.3%**

Table 8.2.7b: Alleged abuse in Residential Care Homes across Kent and Medway by area

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Alleged incidents in residential care homes continue to be a significant part of our work. Within the KCC boundaries alone there are approximately 720 homes, with East Kent having the largest concentration. KCC have implemented the Quality in Care Framework which is having an impact. A further initiative is the quarterly risk meeting with CQC which facilitates information sharing and a co-ordinated response.

Medway has a slight increase in percentage proportion of care home allegations comparing the 3 years. This continues to demonstrate Medway's commitment to improving awareness and practice in care home provider services.

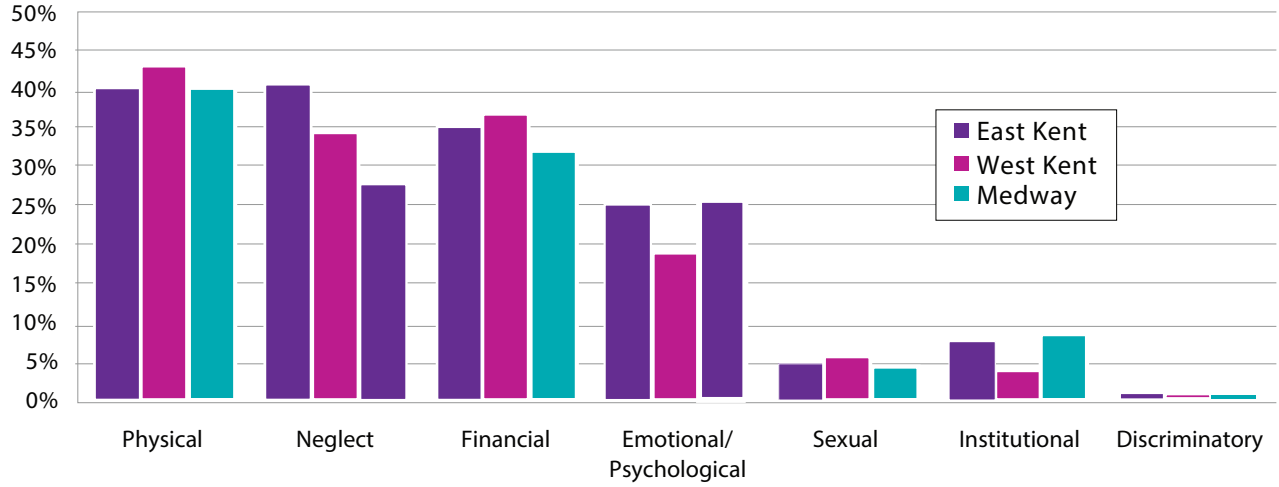
8.2.8 Type of Abuse

The table below shows the categories of abuse as numbers and percentages for 2011 - 2012. There may be multiple types of abuse recorded for one referral.

Type of alleged abuse	East Kent		West Kent		Medway		ALL	
	number	%	number	%	number	%	number	%
Physical	573	37.1%	279	36.1%	144	34.7%	996	36.1%
Neglect	512	33.2%	214	27.7%	128	30.8%	854	31.0%
Financial	372	24.1%	185	23.9%	127	30.6%	684	24.8%
Emotional/ Psychological	296	19.2%	119	15.4%	122	29.4%	537	19.5%
Sexual	96	6.2%	60	7.8%	34	8.2%	190	6.9%
Institutional	82	5.3%	10	1.3%	19	4.6%	111	4.0%
Discriminatory	12	0.8%	4	0.5%	17	4.1%	33	1.2%

Table 8.2.8a: Type of alleged abuse across Kent and Medway by area for 2011-2012 (a referral may have multiple types of abuse recorded - the percentage figures relate to the proportion of referrals where each type was apparent)

Percentage of Incidents of Abuse Categories by Area 2010



Percentage of Incidents of Abuse Categories by Area 2011

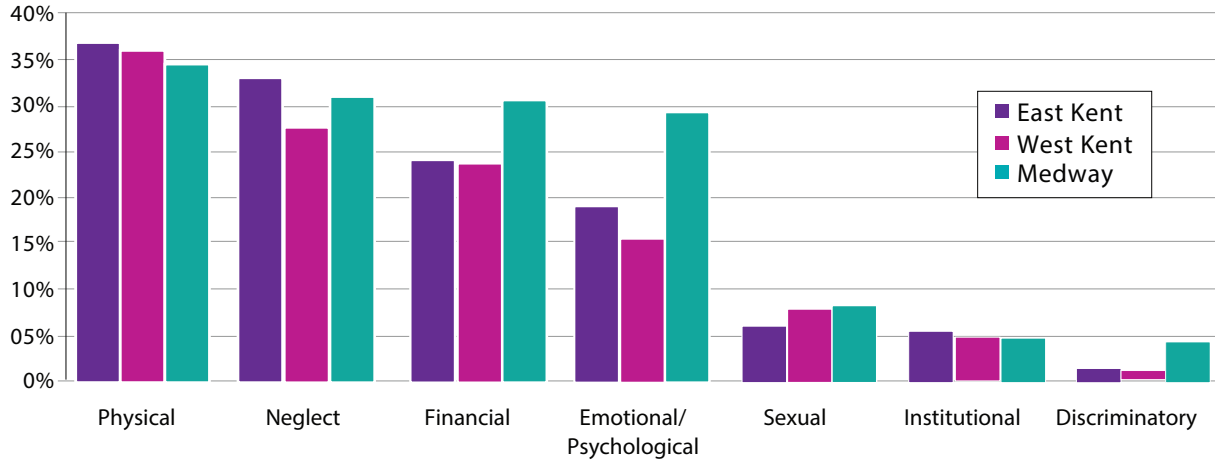


Table 8.2.8b: Type of alleged abuse across Kent and Medway by area for 2011-2012

8 Safeguarding Activity

8.3 Closed Referrals

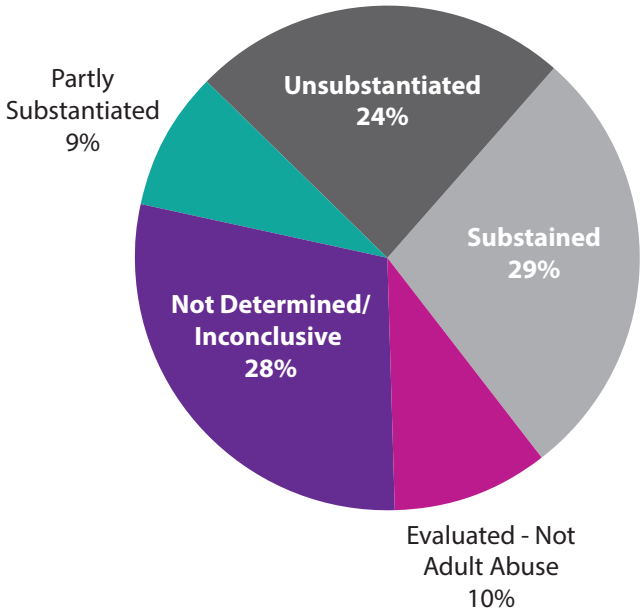
8.3.1 Outcome of Referral

In Medway, following a referral, all vulnerable adults and their carers receive an assessment of their social care needs and onward referral to other services as determined. As a result, although nearly half of the cases were unsubstantiated, alleged victims were able to access guidance and a support/protection plan that is designed to protect them from abuse in the future.

Area	Substantiated	Partly Substantiated	Un-substantiated	Not Determined Inconclusive	Evaluated - Not Adult Abuse
East Kent	31.8%	9.2%	18.1%	32.2%	8.8%
West Kent	28.2%	8.0%	23.7%	25.7%	14.4%
Medway	23.3%	12.7%	48.1%	11.4%	4.6%
All	29.6%	9.4%	23.7%	27.6%	9.8%

Table 8.3.1a: Outcome of closed referrals in 2011-2012 across Kent and Medway by area

Figure 8.3.1: Outcome of referrals closed in 11/12



Area	Substantiated		Partly Substantiated		Un-substantiated		Not Determined Inconclusive		Evaluated - Not Adult Abuse		Total
	no.	%	no.	%	no.	%	no.	%	no.	%	
Ashford & Shepway	223	25.7%	86	9.9%	244	28.1%	219	25.2%	96	11.1%	868
Canterbury & Swale	494	34.6%	136	9.5%	285	20.0%	406	28.5%	106	7.4%	1427
Thanet & Dover	588	41.0%	106	7.4%	270	18.8%	401	28.0%	68	4.7%	1433
East Kent LD	225	35.8%	44	7.0%	119	18.9%	183	29.1%	57	9.1%	628
East Kent Total	1530	35.1%	372	8.5%	918	21.1%	1209	27.8%	327	7.5%	4356
Dartford, Gravesham & Swanley	98	18.2%	38	7.1%	152	28.2%	154	28.6%	97	18.0%	539
Maidstone & Malling	213	32.1%	55	8.3%	171	25.8%	179	27.0%	46	6.9%	664
South West Kent	106	23.0%	36	7.8%	141	30.6%	121	26.2%	57	12.4%	461
West Kent LD	157	37.3%	27	6.4%	81	19.2%	88	20.9%	68	16.2%	421
West Kent Total	574	27.5%	156	7.5%	545	26.1%	542	26.0%	268	12.9%	2085
Central Duty Team	0	0.0%	1	25.0%	0	0.0%	2	50.0%	1	25.0%	4
Medway	174	23.6%	76	10.3%	346	47.0%	89	12.1%	51	6.9%	736
All	**2278**	**31.7%**	**605**	**8.4%**	**1809**	**25.2%**	**1842**	**25.7%**	**647**	**9.0%**	**7181**

Table 8.3.1b: Outcome of closed referrals for the period April 2009 - March 2012 by area

8.4 Kent Police Performance Data 2011 - 12

The following table shows 2011 - 2012 Adult Abuse performance figures. Kent Police have moved from providing Base Command Unit (BCU) or Police Area data to district data. This gives a sharper local focus, both in terms of performance and profile. Interventions from all agencies can be better directed as a result.

Crime/Incident Breakdown	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway
Total Reported Crimes	7	17	14	6	5	11	15
Total Secondary Incidents 11	115	492	141	223	147	150	528
Total	**122**	**509**	**155**	**229**	**152**	**161**	**543**

8 Safeguarding Activity

Crime/Incident Breakdown	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells	Force
Total Reported Crimes	2	8	7	32	2	10	136
Total Secondary Incidents	181	135	142	496	181	208	3139
Total	**184**	**143**	**149**	**528**	**183**	**218**	**3284** (9 No Crimes)

Although direct district to district comparison is not available due to the change in format, there are interesting overall comparisons to be made with 2010 - 11 data. The total number of incidents recorded across Kent in 2010 -11 was 3326, including 158 substantive crimes. This equates to a reduction of 42 incidents (just over 1%) and 22 crimes (14%) versus last year. Although we shouldn't read too much into this one set of figures, it is encouraging, particularly in a climate of increased awareness and sustained public communication on a National and local basis.

There are as expected district variations, and no surprise that the districts with the highest number of recorded incidents are Medway and Thanet, each accounting for 16% of the force total. The figure in relation to Canterbury is higher than similarly populated districts. This may reflect practice at East Kent, and it is expected that a more consistent approach across Kent will be achieved as the multi-agency Central Referral Unit beds in.

The following table shows the breakdown for 2011 - 2012 of the type of crime involved in the Crime/Incident.

Crime Type Breakdown	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway
Emotional	29	83	88	41	103	57	39
Financial	16	55	20	32	18	26	47
Neglect	10	84	18	18	22	47	33
Physical	23	109	42	55	31	64	41
Sexual	13	19	11	14	9	13	13

Crime Type Breakdown	Sevenoaks	Shepway	Swale	Thanet	Tonbridge and Malling	Tunbridge Wells	Force
Emotional	16	29	59	69	21	20	654
Financial	27	19	33	67	18	26	404
Neglect	15	8	28	79	25	27	414
Physical	22	21	58	76	45	25	612
Sexual	4	11	8	23	6	5	149

The above table categorises each incident under the headings of emotional, financial, physical and sexual abuse and neglect. The data relates to those reports that have been further categorised beyond the basic description of incident or crime. Some incidents will have two or more categories.

[1] Secondary incidents consist of referrals (alerts) received by Police from Adult Social Services and from Police to Adult Social Services, nearly all incidents are initially recorded as Secondary Incidents. Those that are substantiated criminal offences are upgraded as a result.

9 Priorities for 2012 - 2013

A number of priorities have been identified for 2012 – 2013:

- Implementing the outcomes from the multi-agency governance review.
- Developing a strategic action plan for the multi-agency partnership.
- Reviewing the multi-agency policy and protocols.
- Reviewing the Serious Case Review policy.
- Implementing the recommendations from the Serious Case Review (June 2011).
- Organising a learning event following the Serious Case Review (June 2011).
- Implementing the recommendations from Domestic Homicide Reviews where they relate to vulnerable adults.
- Updating the e learning package.
- Piloting 3 Train the Trainer courses in service user awareness.
- Launching the safeguarding vulnerable adults easy read leaflet.
- Strengthening links between the Safeguarding Vulnerable Adults Executive Board and the Kent and Medway Safeguarding Children's Board, Community Safety Partnerships and the Kent and Medway Abuse Strategy Group.
- Responding to national safeguarding developments.

Appendices

Appendix 1

Kent and Medway Safeguarding Vulnerable Adults - principles and values

The Kent and Medway Safeguarding Vulnerable Adults multi-agency partnership is underpinned by the following principles and values:

- It is every adult's right to live free from abuse in accordance with the principles of respect, dignity, autonomy, privacy and equity
- All agencies and services should ensure that their own policies and procedures make it clear that they have a zero tolerance of abuse
- Priority will be given to the prevention of abuse by raising the awareness of adult protection issues and by fostering a culture of good practice through support and care provision, commissioning and contracting
- Vulnerable adults who are susceptible or subjected to abuse or mistreatment will receive the highest priority for assessment and support services. All agencies will respond to adult protection concerns with prompt, timely and appropriate action in line with agreed protocols
- These principles are applicable to all adults whether living in a domestic setting, care home, social services or health setting or any community setting
- Protection of vulnerable adults is a multi-agency responsibility and all agencies and services should actively work together to address the abuse of vulnerable adults
- Interventions should be based on the concept of empowerment and participation of the vulnerable individual
- These principles should constitute an integral part of the philosophy and working practices of all agencies involved with vulnerable adults and should not be seen in isolation
- It is the responsibility of all agencies to take steps to ensure that vulnerable adults are discharged from their care to a safe and appropriate setting
- The need to provide support for the carers must be taken into account when planning services for vulnerable adults and a carer's assessment should be offered
- These principles are based upon a commitment to equal opportunities and practice in respect of race, culture, religion, disability, gender, age or sexual orientation

Appendix 2

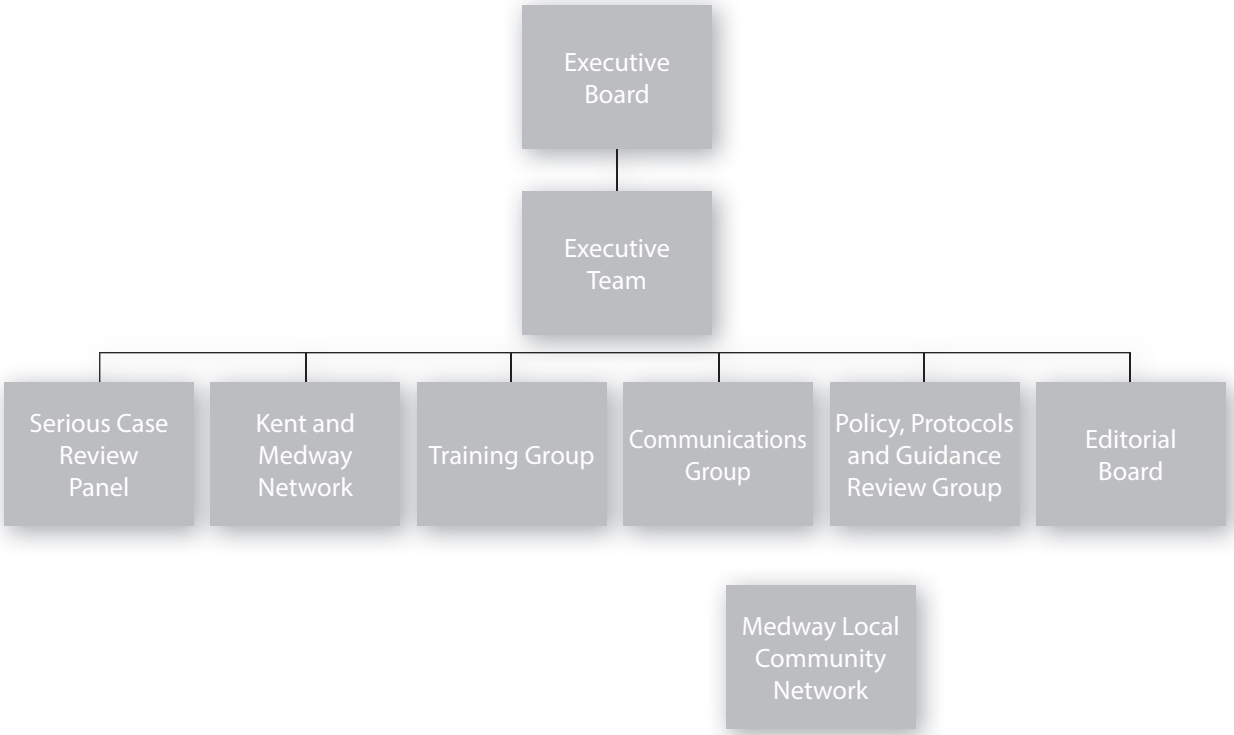
The main forms of abuse

The main forms of abuse are:

- Physical abuse including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
- Sexual abuse including rape and sexual assault or acts to which the vulnerable adult has not consented, or could not consent or was pressurised into consenting
- Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks
- Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
- Neglect or acts of omission, including medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
- Discriminatory abuse, including racist, sexist, that is based on a person's disability, and other forms of harassment, slurs or similar treatment

Appendix 3

Governance structure



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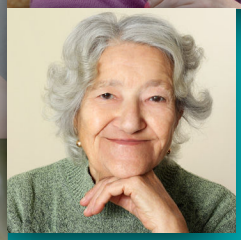

By: Graham Gibbens, Cabinet Member for Adult Social Care & Public Health

Andrew Ireland, Corporate Director Families and Social Care

To: Social Care & Public Health Cabinet Committee – 11 January 2013

Subject: **DEMENTIA - A NEW STAGE IN LIFE: SELECT COMMITTEE ONE YEAR ON REPORT**

Classification: Unrestricted

Summary: This report advises Members of the implementation of the recommendations in Dementia – A New Stage in Life Select Committee report which was published in September 2011.

The report sets out response to the recommendations and, describes actions taken since the publication of the report and the progress made to date.

Introduction

1. (1) The Dementia Select Committee was established by the then Adult Social Services Policy and Overview Scrutiny Committee at the end of 2010 and the final report of the Committee was published in September 2011 and presented to Kent County Council on 5 December 2011.

(2) The Adult Social Care and Public Health Cabinet Committee received a report that outlined the Implementation Plan on the recommendations at its meeting on 30 March 2012.

(3) The Select Committee comprised of nine Members of the County Council; seven Conservative, one Labour (co-opted Member) and one Liberal Democrats. The Members of the Select Committee were Trudy Dean (Chairman), Mrs. Ann Allen, Mr. David Brazier, Mr. Alan Chell, Mr. Les Christie, Mr. John Kirby, Mr. Steve Manion, Mr. Ken Pugh, Mr. Avtar Sandhu.

(4) The Terms of Reference for the Select Committee were to:

- Examined issues around '9 Steps' of 'Quality Outcomes' for people with dementia and their carers in Kent.
- To identify good practice and innovation in Kent and elsewhere, that could
- contribute to achievement of the '9 steps'.
- To identify factors militating against achievement of the '9 steps' and make recommendations for improvements.

(5) The original draft scope included aspects noted below and these were thought to be of most concern to people living with dementia and their carers. These were given greater focus in the review. The key areas were:
prominently in the report:

- Stigma
- Awareness-raising among professionals
- Inclusiveness of training, care and support
- Early diagnosis
- Post-diagnosis support
- Carers
- Technology
- Information, advice and signposting
- Decision-making
- Personalisation
- Person-centred care

(6) The Dementia Select Committee report made a total of 17 recommendations for further action. Please see Appendix 1 for details of progress to date in respect of the recommendations.

(7) The Select Committee received both written and oral evidence from a wide range of stakeholders including representatives of local and national dementia support organisations, officers from Kent County Council, NHS Trusts, carers and District and Borough Councils.

(3) In line with the Kent County Council constitution arrangements are in hand for the Select Committee to be reconvened, one year on, to review the progress made on the recommendations. Subject to availability the meeting will take place in early February 2013.

Recommendations

8. (1) Members are asked to NOTE and COMMENT on the progress report to date.

(2) NOTE that the Dementia Select Committee is to be reconvened to review the progress on the recommendations.

Appendix

Appendix 1: Dementia Select Committee Implementation Plan Update.

Background Documents

Dementia – A New Stage in Life Select Committee Report, September 2011.

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Appendix 1

DEMENTIA SELECT COMMITTEE RECOMMENDATIONS IMPLEMENTATION PLAN – Update December 2012

THEME: DEMENTIA IN KENT				
Recommendation Description	**Lead Person Responsible Agency**	**Action**	**Progress**	**RAG rating**
R1 That a business case is developed in Kent for shared care prescribing arrangements or dementia medication and that GPs are encouraged to be more proactive in reviewing all people diagnosed with dementia, regardless of whether dementia medication is indicated. (p50)	**Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway	It is the intention of the NHS to commission a Primary Care Dementia Pathway which ensures that dementia is viewed and treated alongside other long term conditions. Crucial to the success of this pathway will be ensuring that primary care clinicians are supported to develop skills in the identification, assessment management of dementia including the management and review of medications.	**The successful Dementia Challenge Fund Bid will support the implementation of a primary care focused diagnostic pathway which will include shared care for dementia medication. Shared care protocol has been agreed and funding transfer from KMPT to primary care agreed.** **Training programme for GPs due to be scoped. WK CCG challenge fund bid will provide primary care practitioners and training for KMPT nurses to support primary care, part of the role will include supporting medication reviews. This role of primary care practitioner will be rolled out as part of the implementation of Cluster 18 in Mental Health Payment by Results Scheme, due to come into effect in shadow form from 1.4.13.**	
R2 That in disposing of KCC buildings, the options for Community Asset Transfer are proactively explored to maximise the opportunity for voluntary sector dementia respite and day services. (p54)	**Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council	Develop an options appraisal/business case where appropriate regarding specific properties that balance the social value of community asset transfer for schemes against the capital strategy. Options appraisal to be presented to Older People's Project Executive	**The Limes a KCC ex care home property in Dartford, a local Dementia Charity Alzheimer's and Dementia Support Services interested in using property as a Dementia Hub to run services including day care. Property currently leased to pupil referral service until August 2013.**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R3 That KCC seeks to work with Dementia UK and relevant health organisations including GP practices in Kent to explore ways of widening access to the Admiral Nursing Service in Kent so that more people with dementia and their carers have access to a named, specialist contact. (p57)	**Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway	The role and function of the Admiral Nurses is being reviewed within the development of the Primary Care Dementia Pathway, see recommendation 1 There is a countywide Admiral Nurse Steering Group overseeing practice developments, including a pilot in the Maidstone loacility where Admiral Nurses are linked to GP surgeries.	**The role of Admiral Nurses continues to be reviewed as part of the introduction of Mental Health Payment by Results and the implementation of a primary care focused diagnostic pathway.**	
R4 That, to improve the rates of early diagnosis of dementia in Kent, KCC: Works with colleagues in Public Health, the Voluntary Sector, community and faith groups to raise awareness (and dispel appropriate dementia screening tool in the NHS Health Checks programme in Kent (and adherence to relevant NICE guidance.	**Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway	A key aim of The Kent and Medway Dementia Integrated Plan is to improve current diagnosis rates. NHS commissioners are working with The Kent & Medway Partnership Trust (KMPT) to review the role and function of the current memory assessment services to ensure they are as efficient and effective as possible. Work is underway to develop a differentiated model of assessment with less complex assessments being completed in primary care as part of the Primary Care Dementia Pathway.	**See also R1 above. The Challenge Fund will support the implementation of primary care focused diagnostic pathway. Also includes funding for introduction of i-pad technology to support dementia assessments in primary care. Implementation of Mental Health Payments by Results will clarify the role of memory assessment services. Revised specification being prepared for inclusion in 2013-4 contract with KMPT.** **Communication plan implemented to continue to raise awareness of dementia. New Dementia Friendly Communities Project will support awareness raising campaigns'.**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R5 That to ensure young people have a good understanding of dementia, KCC:- ▪ Ensures libraries in Kent have books which explain dementia to children of different ages and encourages schools to do so. ▪ Seeks to fund a youth project to create a DVD, raising awareness about dementia and encouraging inter-generational support, which could be shown in Kent schools. (p82)	**Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council	These actions are included as part of the current Kent County Council Social Innovations Lab Kent (SILK) Dementia Co-Production project. Swale Young Carers Project is working with co-production project team at SILK to develop a DVD and booklet to explain dementia to children. Additional resources have been allocated to Kent Libraries to ensure a good stock of books is available, including reminiscence aids which can be loaned to providers	**Well on way to achieving all targets in attached libraries and Gateways Action Plan. Considerable amount of work with Tricia Fincher from Libraries and Stephen Meades from Gateways to develop and action attached plan.** Libraries Gateways Dementia Action Plan LRA Update re Dementia Action Plan **SILK Co-Production Team is continuing to develop a range of resources to support raising awareness of dementia in schools with children.**	
R6 That KCC acknowledges and highlights the perspective of carers (and former carers) for people with dementia in a '9 steps for dementia carers' for inclusion in the next Kent Carers' Annual Report.	**Michael Thomas-Sam** Interim Strategic Business Adviser Families and Social Care Kent County Council	To consult with the Carers Advisory and Carers Reference Group on the "9 steps for dementia carers". Depending on the consultation feedback the nine steps will then be reflected in the next Kent Carers Annual Report which is due to published in Summer 2012.	**A decision has been made that in future reporting on carers will be included in the annual Local Account Report that Adults Services will produce. The 2011/12 report contains a section on carers. The 2012/13 will better reflect the '9 steps'.** **The 9 steps has informed commissioning services for carers as part of the implementation of the Kent Carers Strategy.**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R7 That KCC encourages the commissioning of a variety of early intervention measures in order to reduce avoidable, inappropriate and expensive hospital admissions for people with dementia, to improve quality of life and outcomes for a greater number of people with dementia and carers and that commissioning should include:-	**Mark Lobban** Director of Strategic Commissioning Families and Social Care Kent County Council	An Adult Social Care Transformation Blueprint is currently being developed in partnership with stakeholders. The blueprint will be presented to Cabinet Members Meeting on April 16th 2012. Central to the transformation programme is the development of more proactive services, including targeted prevention designed promote independence and reduce costly and unnecessary crisis situations.	**The Investment appraisals for the use of the Social Care Monies for health outcomes includes numerous schemes designed to prevent hospital admissions and support timely and safe discharges.** **The successful West Kent Dementia Crisis Services has been expanded into East Kent. This service provides dedicated and highly trained support workers who respond within 2 hrs providing up to 24hr care to better manage crisis situations and ensure. West Kent CCG successfully bid to extend the scope of the crisis service and are starting a pilot project using the provider Crossroads in an innovative way in Pembury hospital to prevent admissions and take people home with full support.**	
Implementation of a pilot Shared Lives scheme for people with dementia, in co-operation with PSSRU Kent, which develops the current Adult Placement Scheme and explores whether the management of personal budgets by voluntary sector service providers could help to provide more person centred respite, for example, for people in rural areas using the Shared Lives Model.	**Jane Barnes** (Shared Lives Lead) Head of Adult Service Maidstone and Malling Families and Social Care Kent County Council	A review of the Kent Adult Placement Scheme is underway, one of the aims of the review is to ensure that the scheme develops to meet the needs of people with dementia and their carers; a working group has been established to oversee this. Consideration currently is being given to developing a research project to look at Adult Placement Scheme/Shared Lives model for dementia. Kent has agreed in principle to be part of research project for a period of up to 2 years.	**KCC was successful in bidding via South East Dementia Challenge Fund for additional resources to develop the adult placement scheme to deliver a Dementia Shared Lives Project. This funding will provide dedicated resources to recruit and train host family workers and to work with Case Management teams to ensure the scheme is used as a viable alternative to care home placements. We will also work with host family workers to develop models of day care and respite short-breaks.**	

Independent Dementia Advocacy Services for people with dementia in East Kent.	**Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council	Review existing arrangements for the provision of Independent Dementia Advocacy, currently only available in West Kent. Create Business case and secure funding to ensure Independent Dementia Advocacy is consistently available across Kent.	**Commissioning Strategy for all advocacy services being developed – within which the specific needs of people with Dementia will be captured. West Kent Service Extended to March 2014, Age concerns have had 5% of budget top sliced and advocacy an area in which they have been encouraged to develop new services.**	
R8 That KCC seeks to promote greater awareness of Lasting Powers of Attorney (LPA) and considers whether a service could be offered by KCC Legal Services in this regard and that KCC supports the work of the British Banking Association to improve training for staff on LPA in order to minimise stress experienced by carers for people with dementia in organising finances. (p97)	**Michael Thomas-Sam** Interim Strategic Business Adviser Families and Social Care Kent County Council	To liaise with KCC Legal Services and explore opportunities for raising awareness of Lasting Power of Attorney (LPA) with the public and professionals. To consult with KCC Legal Services on the establishment of ongoing and refresher LPA training for KCC and Health staff and also potential service development of specialist legal services for people with dementia.	**Legal Services have undertaken to raise awareness of the issue working with FSC health and social care organisations in Kent.** **KCC Legal Services has provided training for over 97 frontline staff. Ongoing and refresher LPA training is reflected in the KCC training and development strategy for staff.**	☺
R9 That KCC works with Kent Police and relevant health organisations to ensure there is proactive support for and appropriate responses to carers who may be experiencing domestic violence as a result of dementia-related aggression in a loved one. (p99)	**Michael Thomas-Sam** Interim Strategic Business Adviser Families and Social Care Kent County Council	Following discussion with the KCC Community Safety Manager, a meeting has been arranged with Kent Police on how this recommendation can be taken forward. This is also an agenda item for discussion at the Kent and Medway Domestic Abuse Strategy Group in May 2012 and will also inform the next KCC Select Committee on Domestic Abuse. Following on from this the intention is to look at ways of increasing awareness and training delivery of key staff and partner agencies.	**The outcome of the discussion with the Kent and Medway Domestic Abuse Strategy Group was that the key agencies, such as Kent Police, Ambulance Service, care providers, voluntary sectors group and social services will reflect this issue is their training.** **The multi-agency protocol provides guidance to all agencies in referring cases of concern to appropriate service (see 1.2). These will normally be addressed through the Multi- Agency Adult Protection Policy, Protocols and Guidance for Kent and Medway (2011)**	☺

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R10 That KCC extends the successful Telecare pilot work by evaluating how different types of assistive technology can support people with dementia to live safely and securely at home and in particular to assist with 'safer walking'. (p104)	**Hazel Price** Project Manager – Tele Technology Families and Social Care Kent County Council	FSC are currently in the process of procuring of range of new technologies to support the independence and positive risk management for people living with dementia. The impact and outcomes for using these new technologies will be evaluated.	**Commissioning Plan being developed and included as part of transformation plans to procure and test out a range of dementia specific tele technology including the use of GPS tracking devices, design to promote safety independence and positive risk management.**	
R11 That KCC ensures that people living with dementia and their carers have access to good quality, well maintained information on local services and support in Kent and in their local area and that: ▪ Printable, district level information is made available through links on DementiaWeb. ▪ KCC works with relevant health organisations and partners in the voluntary sector to ensure that this standard information 'set' is known to/made available through local authority offices, Gateways, Citizens Advice Bureaux, dementia and carer support organisations and in particular GP surgeries. ▪ As well as signposting to local groups offering dementia support DementiaWeb provides information about Adult Education opportunities and details of the Health Referral	**Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council **Lydia Jackson** Project Officer Families and Social Care Kent County Council	The information requirements of people with dementia and their carers has been a key theme of the current KCC Dementia Co-Production Project. We are working with people with dementia and their families and carers to improve our advice, information and guidance strategy. We are review and evaluate DementiaWeb and the Kent 24 hr Dementia Helpline. Including how they are publicised to ensure maximum take-up. Ensure that fact sheets are available and downloadable from the site. Working with Kent Gateways and Kent Libraries to ensure they are able to signpost people to DementiaWeb and the 24hr Helpline. Develop bespoke training for both services to ensure they are dementia aware. Ensure that DementiaWeb contains	**SILK Co-production work has completed user testing of DementiaWeb and recommendations for changes to format and content have been made to provider who has taken on board and is make changes.** **There will shortly be a bus campaign to promote both DementiaWeb and the 24Hr Helpline.** **On target see Libraries and Gateways Dementia Action Plan** **Improving Advice, Information and Guidance is a central theme to the transformation of Adult Services – work is underway to co-produce with users and voluntary sector partners. This includes an overhaul of out KCC website to ensure it is more user friendly.**	

Scheme (50% discount on courses), and Library services for people with dementia. There is a consistent approach to the provision of information and signposting by KCC in response to enquiries regarding people with dementia who are self funded, ensuring that all enquirers are made aware of DementiaWeb and the local information guides. (p111)		links to Adult Education Classes and support offered by Kent Libraries. Contribute to development of Adult Social Care Commissioning Strategy (2013 – 2016) for Advocacy, Information, Advice and Guidance Services; too ensure the needs of people with dementia and their carers are fully met.		
R12 That KCC and Health Commissioners should ensure that every Kent district or borough has at least one memory cafe as well as peer support for people with dementia. That KCC should promote the grass roots development of a network of memory cafes and peer support by engaging local groups such as Rotary, U3A, Older Person's forums, Carer Support Groups and Neighbourhood Watch; encouraging them to apply for funding through Members' Community Grants. (p115)	**Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council	KCC is currently in the process of awarding grants to ensure that there is a Peer Support Group and a Dementia Café in every local authority district throughout Kent. Once the grant agreements have been awarded a county best practice group will be established to help providers develop services and maximise impact.	**Commissioned and available in every local authority district a project group has been established and quarterly meetings are held with providers to performance manage, support, problem solving and share best practice.** **Attendance is growing and feedback from attendee is very positive.**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R13 That in establishing and developing the 'core offer' of services and support for people with dementia and their carers, KCC and NHS Dementia Service Commissioners build on existing links with the academic sector (particularly the Dementia Services Development Centre at Canterbury Christ Church University and PSSRU at the University of Kent) to maximise research opportunities and ensure that the development of the dementia care pathway in Kent is informed by evidence and best practice. (p120)	**Mark Lobban** Director of Strategic Commissioning Families and Social Care Kent County Council **Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council **Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway	The development of consistent core offer including preventative and universal services will be key feature of commissioning strategy to support implementation of Kent and Medway Integrated Plan and the Kent County Council Adult Service Transformation Programme. We recognise that across Kent there is variation in services we are developing standard offer in consultation with people living with dementia and their carers as part of our Co-Production Project. Understanding what services are most valued by users and why and ensuring they are universally available and strategically aligned to promote independence well-being and choice and prevent wherever possible crisis situation occurring.	**Actions contained within Dementia Integrated Plan and ASC Transformation Blueprint – new funds that we are currently bidding for will enable greater consistency of approach.** **KCC FSC new Strategic Commissioning unit for Community Based Adult Services is reviewing all community support services. Mapping and analysis of preventative services funded through voluntary sector grants to develop a core offer.** **One of the recently successful NHS South Dementia Challenge Bids is to develop Dementia Friendly Communities. Through this project will work with to develop a Dementia Friendly community in each of the 12 Kent Districts or Boroughs. These projects will support further development of dementia services across Kent.** **Using our well established model of co-production to ensure services are what people both need and want.** **All Challenge fund bids include funding for evaluation to ensure that practice can be validated and shared with others.** **Dementia Collaborative continues to strengthen links with Universities in Kent research into dementia.**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R14 That, given the high proportion of undiagnosed dementia in Kent, '2nd level' training in dementia should be compulsory for all KCC assessment and enablement workers and basic dementia awareness training should be strongly encouraged for other KCC staff engaged in dementia support work and a requirement for an appropriate level of dementia training should be reflected in contractual arrangements with providers. (p121)	**Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council	A business case is being prepared to secure funds in order to deliver 2nd level or more advance skills in working with people with dementia and their carers for all adult service frontline workers. Dementia specific training and competency requirements will be a key feature of all new service specifications. Mark Lobban Director of Strategic Commissioning has issued guidance to all commissioning staff to ensure this happens.	**Developing training plan with ALRT to ensure training is available. Additional cost will be calculated** **We have a well established programme developed in partnership and delivered by Dementia UK – charity that provides Admiral nursing. Training in of a high quality and includes additional courses for in house provider units including person centred activities.**	
R15 That KCC (through the Health and Wellbeing Board, where appropriate): ▪ Encourages GP practices to invite voluntary sector dementia support organisations to protected learning sessions to raise awareness among clinical and non-clinical staff about dementia and the local support available for people with memory problems. ▪ Focuses on maximising KCC's role in the training and development of the social care workforce to ensure the safety	**Anne Tidmarsh** Director of Older People's and Physical Disability Provision Families and Social Care Kent County Council **Emma Hanson** Head of Strategic Commissioning Families and Social Care	Dementia has been selected as an area for priority consideration by the Health and Well Being Board. Development of Dementia Service in Kent will be an agenda item as the March 2012 Board. The Dementia Select Committee Recommendations and Action Plan will be included in the papers presented to the board. KCC has invested in a significant programme of highly quality dementia specific training for all operational staff; and has continued to offer dementia training to the private and voluntary	**Work in progress and linked to Actions contained within Dementia Integrated Plan and ASC Transformation Blueprint.** **KCC is Woking with the Kent and Medway Care Alliance to review the way training is procured and delivered to the care sector we are investigating ways of supporting the sector to have more control about the type and range of training provided.** **GP and allied health professionals training was a key element of several of the recently successful South Dementia Challenge Fund Bids – a programme of awareness and skills based learning is being developed across kent and Medway. This will include training for acute hospital staff,**	

and quality of care for people living with dementia are given the highest priority. ▪ Encourages the commissioning of joint education and training for health and social care professionals including General Practitioners, on dementia to support integrated working in the future. ▪ Encourages greater awareness among hospital staff in Kent about when to engage with liaison nurses to minimise admissions, reduce lengths of stay, ensure dignified care and speed up discharges to appropriate locations for people with dementia in order to minimise distress and contribute to cost savings. Encourages relevant health organisations, including GP practises and partners in the voluntary sector to identify opportunities for pooled health and social care funding of community based care co-ordinators (see recommendation2) and that personalised multi-agency care plans can be readily accessed by professionals providing care and support to people with dementia at home and during transitions of care.	Kent County Council **Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway	sector. Going forward consideration will be give to the benefits of developing a joint education and training strategy across Health and Social Care. To cover all elements recommended by select committee. The reduction in inappropriate non elective or emergency care is a central aim of the Kent and Medway Dementia Integrated Plan. Opportunities for joint working and commissioning will be fully investigated through Transformation Programme and Health and Socail Care Integration Programme (HASCIP). Tis will include developing flexible models of support that operate 24/7 and are focussed on crisis prevention, admission avoidance and discharge facilitation. Kent County Council does not categorise service users according to their medical conditions, therefore it is	**community nursing staff and primary care staff including GPs.** **Kent County Council and the Kent and Medway Partnership Trust have developed in partnership with the Bradford Dementia Group, a training and support package for care homes designed to bring about sustainable change and embed person centred approaches in practice. The approach involves three different training programmes including the use of Dementia Care Mapping DCM.** **DCM is a method designed to evaluate quality of care from the perspective of the resident. It is based on the philosophy of person-centred care, which promotes a holistic approach to care that upholds the personhood of the person with dementia. We are monitoring baseline and outcome indicators to measure change and the effectiveness of this innovative approach to whole system change.** **The treatment and support for dementia as a long term health condition is a key element of the Health and Social Care Integration Programme (HASCIP).** **A blue print Integrated Commissioning Plan has been developed in the Dover area in partnership with the local CCG and Dover District Council. We hope to use this template and agree similar plans in all other CCG areas. Improving long term condition management including dementia care is a central theme.** **Approx 80% of Adult Service clients have been cross matched with their NHS numbers. This is an important step in developing risk stratification**	

▪ Identifies as a matter of urgency the approximate current spend on dementia by all agencies and models the change in spend between providers as diagnosis rates improve. This will provide a benchmark for the development of services and a context for assessing the value both in cost and quality of provision of pooled budgets and preventative services (p128/9).		difficult to accurately calculate the cost of dementia care A percentage estimates has been applied to all budgets lines – which clearly shows that the majority of KCC spend on dementia is with the care home sector. Further work is needed to calculate the NHS spend on dementia, due to the low formal diagnosis rates and the lack of use of codes which would identify people with dementia using NHS services it is difficult to say with accuracy the actual current cost of services used by people with dementia in Kent. Though it is known that most NHS spend is on bed based inpatient care. KCC and the NHS is currently exploring the option of purchasing a whole systems modelling tool, or developing local shared information tool which will help to identify when funds are currently allocated, the priorities for service development and identify which service areas will have the most impact in managing the predicted increase in the number of people with dementia.	**across Kent allowing KCC and the NHS to identify the true cost of care and identify people most at risk of deterioration, crisis and hospital admission.** **An initial scoping of the impact of the increase in prevalence of dementia on service provision has been carried out by public health but requires further analysis and discussion with commissioners.** **Reducing unnecessary and unplanned admission is central to the transformation of adult social care. Current options appraisals are being develop for the use of the NHS allocation to Adult Social Care – including the development of integrated crisis and admission avoidance schemes**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R16 That KCC considers whether a separate Kent & Medway Strategy for Younger Onset Dementia is required to ensure that the needs of this group are met and that any future dementia strategy or plan: • takes account of the particular circumstances experienced by a younger age group and the development of appropriate services and support based on evidence and best practice. • includes an assessment of the likely impact of increased numbers of people with learning disabilities having dementia in the future. ▪ is proactive in mapping where support and services will be needed. (p130)	**Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway **Anne Tidmarsh** Director of Older People's and Physical Disability Provision Families and Social Care Kent County Council **Emma Hanson** Head of Strategic Commissioning Families and Social Care Kent County Council	Dementia Integrated Plan Board to discuss the need for a Kent & Medway Strategy for Younger Onset Dementia. To complete a needs analysis, including service mapping for younger adults with Dementia. Promote the use of personal budgets to meet the needs of younger adults with dementia. Encourage younger adults to attend dementia Peer Support groups and consider setting up younger onset group. Monitor impact of new assessment pathway to ensure the timely and effective assessment of people with a Learning Disability who go on to develop dementia symptoms. A multi disciplinary group has been set up to performance manage the new pathway. Two sucessful learning events have been held and there is a programme of training for KCC staff and providers.	**Work in progress and linked to Actions contained within Dementia Integrated Plan and ASC Transformation Blueprint** **Dementia Peer Support Groups have been attracted younger people diagnosed with Dementia. As part of the Dementia Libraries and Gateways project a DVD featuring Keith Oliver a Kent ex Primary School head who was diagnosed in his fifties has been produce to help raise awareness.** **LD & Dementia Subgroups meets quarterly to performance manage and problem solve issues with the pathway**	

Recommendation Description	Lead Person Responsible Agency	Action	Progress	RAG rating
R17 That Hospital staff in Kent should be made aware of the need to engage with liaison nurses to minimise admissions, reduce lengths of stay, ensure dignified care and speed up discharge to appropriate locations for people with dementia in order to minimise distress and contribute to cost savings. (p124)	**Sue Gratton** Deputy Associate Director, Integrated Commissioning NHS Kent and Medway	Liaison psychiatry services have a key role in helping to support acute hospital staff in the management of people with dementia. This service is already in place in East Kent and is being implemented in Medway and plans are being developed to implement this service in West Kent. Monitor new national CQUIN (Commissioning for Quality and Innovation) being introduced across all acute and community providers in Kent and Medway to screen all people over the age of 75 years for dementia with a view to increasing diagnosis rates. All Acute Hospital Trust in Kent now have Dementia Strategy Implementation Groups, developed action plans and are tasked with improving the experience of people living with Dementia whilst using acute services. Commissioners to monitor progress of plans and share best practice across Kent.	**All Acute Trusts are actively implementing the national CQUIN for dementia. Data on numbers of people screened, assessed and referred for further investigation will be available in new year. This work has helped to increase awareness of dementia among hospital staff.** **Challenge Fund Bid for acute trusts was successful. This funding will support environmental improvements, staff training and implementation of volunteer buddy scheme modelled on the successful Darent Valley scheme. All acute Trusts will be required to sign up to the Dementia Action Alliance.** **The potential for a shared care ward is being explored with EKHUFT and KMPT.**	

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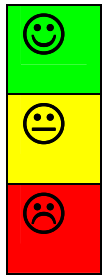

= Complete/advanced progress

= Some good progress although more to do

= Little/no significant progress yet/high risk (therefore high priority next steps)

By:	Jenny Whittle, Cabinet Member for Specialist Children's Services
	Andrew Ireland, Corporate Director Families and Social Care
To:	Social Care & Public Health Cabinet Committee 11 January 2013
Subject:	**CAMHS Update**
Classification:	Unrestricted

Summary: This report updates the Cabinet Committee on the Community Children and Young People's Mental Health Services (CAMHS).

1. Introduction

1.1 In July 2011, Kent County Council Cabinet Members and NHS Kent & Medway agreed to align funding in order to jointly commission new Emotional Well-being and Mental Health Services for children and young people. It was agreed that the new services would take the form of an Emotional Well-being Service delivering support within universal settings (Tier 1 - 2), alongside a 'Community CAMHS' model comprising targeted (Tier 2) and specialist (Tier 3) mental health services.

1.2 On 1st September 2012, Sussex Partnership NHS Foundation Trust (SPFT) commenced delivery of Community Children and Young People's Mental Health Services (CAMHS), with Kent and Medway NHS as lead commissioner. KCC commissioned the Emotional Health and Well-being Service which commenced on the 3rd September 2012 (Young Healthy Minds). Each element of service has been aligned to ensure clear pathways for children and young people between the different tiers.

1.3 Currently mental health treatment and support services for children in care in Kent are provided by separate teams. The tier 2/3 mental health assessment and treatment service is provided by the mainstream CAMHS teams and support to the network of professionals is provided by the ACCENT service. The mental health service for adopted children is currently provided by mainstream CAMHS.

1.4 The KCC contribution includes the total budget for the ACCENT service and the health/clinical element of Treatment Foster Care. Health staff working in both these services has TUPE transferred over for the start of the contract.

1.5 Fortnightly meetings are being held with SPFT to monitor transition arrangements and monthly performance meetings have started.

2. Financial Information

2.1 The annual total value of the children and young people's mental health service is £14m of which KCC contributes £1m. The value of the Young Healthy Minds contract is £1,184, 468.

2.2 KCC funding comprises;

- £722,000 – ACCENT service (this includes funding for two social work posts)
- £120,000 – Previously allocated to Catch 22 (16-18 service).
- £146,00 – Multi Dimensional Treatment Foster Care (3 clinical posts employed by Health)
- £12,000 – FSC budget.

3. Bold Steps for Kent and Policy Framework

3.1 This work underpins the following priorities in Bold Steps for Kent;

- Improve how we procure and commission services
- Support the transformation of health and social care in Kent
- Ensure all pupils meet their full potential
- Improve services for the most vulnerable people in Kent.

4. A Continuum of Health and Well-being Services for Children and Young People

4.1 Following the establishment of the Early Intervention and Prevention (EIP) Framework there is now a range of early intervention services to meet the emotional health and well-being needs of children and young people. An early intervention Emotional Health and Well-being Service is provided by consortia under the umbrella of Young Healthy Minds (YHM)[1]. Access to this service is via the Common Assessment Framework (CAF).There is now a pathway and process in place for referrals between YHM and CAMHS.

4.2 YHM engage individual children and young people who are experiencing, or at risk of experiencing, low-level emotional difficulties and will offer time-limited group or 1-1support.

[1] Kent Children's Fund Network, Family Action, CXK, Stepahead support

4.3 Currently 80% of referrals to CAMHS are from GPs. GPs can refer to CAMHS through a single point in East Kent where the referral will be triaged and processed accordingly. The plan is to set up similar arrangements in West and South Kent. GPs can now refer directly to YHM by completing a CAF. There is a concern that GPs do not have the capacity to complete a common assessment. Solutions to support GPs with CAF are being investigated by health and KCC commissioners; one of which involves having a time limited dedicated resource to complete CAFs and provide training to GPs to do this in future.

4.4 Commissioners are continuing to promote the new EIP Framework and pathway to ensure other agencies are clear that they can refer to CAMHS. Of particular importance is the future relationship between schools and CAMHS. Schools will be able to refer directly to CAMHS through the access point and to discuss a referral for advice as necessary. Commissioners in partnership with Sussex will be publicising information to schools, GPs, Children's services and other agencies about the revised referral process in the New Year when the model is in place. The school nursing service is expected to promote good emotional wellbeing and mental health and offer support to children, young people and their families as appropriate. Where necessary staff will consult with and refer to CAMHS as required.

5. Children In Care and Adopted Children Provision within CAMHS Contract

5.1 SPFT has conducted a review of the children in care (CIC) element (which is the KCC contribution) of the contract. This review has been undertaken in partnership with Health commissioners and KCC. A revised model has been designed to deliver an effective and timely service using a robust model and approach which has been positively received by colleagues in social care and health.

5.2 The new model for CAMHS for CIC and adopted children will improve service delivery by:

- Widening the eligibility criteria to include adopted children and those placed with connected persons
- Creating multi-disciplinary teams led by social workers with specialism in mental health and based within the CAMHS teams
- Increasing the provision, to meet anticipated demand, from the current level of 7% to 30% of Kent's CIC and Adopted Children.

5.3 These changes will not cost more than the existing KCC contribution to the CAMHS contract (£1m). Consultation with staff affected by the proposed change is due to start shortly.

5.4 In the interim The ACCENT service continues to provide advice and support to the team around the Child in Care and is currently supporting 170 Kent children and young people.

6. Waiting Times and Interface between CAMHS and EIP Service

6.1 When SPFT commenced delivery of the CAMHS contract there was a significant number of children on the waiting list, especially in the west of the county. An action plan has been developed to address this (attached as appendix 1). All cases are currently being triaged to ensure that the children and young people receive an appropriate service from either CAMHS or the local EIP provider.

6.2 In East Kent most areas are now seeing young people within 4 weeks however there are some longer waits for specific treatment notably for ADHD and ASD. Further work will be undertaken with agencies to clarify and improve the pathway for these young people, including work with new EIP providers.

6.3 In West Kent waiting times continue to cause concern and are considerably longer, with waiting times for some non-urgent treatment being between 6 months and a year. The provider is working through its action plan to reduce the average waiting time for a first appointment down to within 18 weeks by the end of December 2012.

6.4 SPFT has agreed a trajectory for recovery with commissioners and the plan is that by April 2013 all first appointments will be seen within 4-6 weeks. (See appendix 2) There will however remain a period where some treatments will require longer waits until such time as staff are recruited and/or trained to provide this.

6.6 The action plan has resulted in an increase in pressure for YHM which they have responded to flexibly and cooperatively. Over 120 children and young people have been identified from the east Kent waiting list as appropriate for a YHM service. It is expected that this number will be significantly more in West Kent. An outcome of the introduction of the YHM service is to see a reduction in referrals into specialist teams in the future

6.7 It is recognised that there are longer term tensions between some elements of the health service having the time and capacity to complete an initial common assessment, solutions to which are being investigated in partnership with health and KCC commissioning and early intervention services, which include YHM.

7. Waiting List by Type of Referral

7.1 The provider has undertaken some work on the waiting list to ascertain 'who is waiting' and 'for what' (see appendix 3). This shows that in terms of assessment the largest group waiting is those referred for behavioural support issues including conduct disorder. This amounts to 41% of all referrals waiting for an assessment.

7.2 This is the first time commissioners have seen this information in any detail and raises further questions about how appropriate such referrals are. SPFT will undertake further work in this area as CAMHS may not be the most appropriate service for behavioural issues.

7.3 The next largest groups are those requiring talking therapies and referrals for anxiety totalling 29% of referrals awaiting assessment. NHS Kent and Medway have recently accessed some additional funding from the Strategic Health Authority to provide training for CAMHS staff in Improved Access to Psychological Therapies (IAPT) interventions, which will increase capacity for providing talking therapies and therefore reduce the time children and young people need to wait for this treatment

7.3 In terms of those waiting for treatment the largest group waiting is for those associated with ADHD which accounts for 21%. The second largest group is for those associated with ASD at 15%. The remainder of the picture is fairly evenly spread. There are specific issues around these particular pathways that require a more 'joined up approach' between other professionals and agencies e.g. paediatrics. Commissioners are looking at ways of improving this and ensuring more consistency across Kent.

8. Transition

8.1 It is becoming increasingly apparent that further work needs to take place with regard to the transition of young people from children and young people's mental health services into adult mental health services at the age of 18. There is a gap in provision that cannot be met by the current contract alone; therefore it is our joint intention to look holistically at the issue of transition with adult mental health services and a workshop is being planned for the New Year.

9. Conclusion

9.1 Implementation of the new contract is progressing well but a considerable amount of work is required to improve mental health services for children and young people in Kent. Health and KCC Commissioners are meeting every two weeks with the provider to monitor the implementation plan and performance.

9.2 The launch event took place on 22nd November 2012. Raising awareness of the new Community Children and Young People's Mental Health Service and the new referral routes is a key issue to ensuring that children and young people get the service they need in a timely way. SPFT are developing a communications strategy to address this with GPs and partners agencies

9.3 SPFT is working closely with the new emotional wellbeing provider, Young Healthy Minds, with regards to a clear understanding about pathways for future referrals Training on the Common Assessment Framework is also being made available.

9.4 In taking over the service a key area that SPFT has to resolve is the long waiting times, in some areas and for some treatment this can be up to a year. This is being addressed through an action plan. A trajectory has been agreed with commissioners so that by April 2013 all young people will be seen for a first appointment within 4-6 weeks of referral.

9.5 The new service will be able to support 30% of Kent Children in Care and Adopted children; this is an increase of 23% from the previous fragmented services.

10. Recommendations

To note the contents of the paper.

11. Contact details

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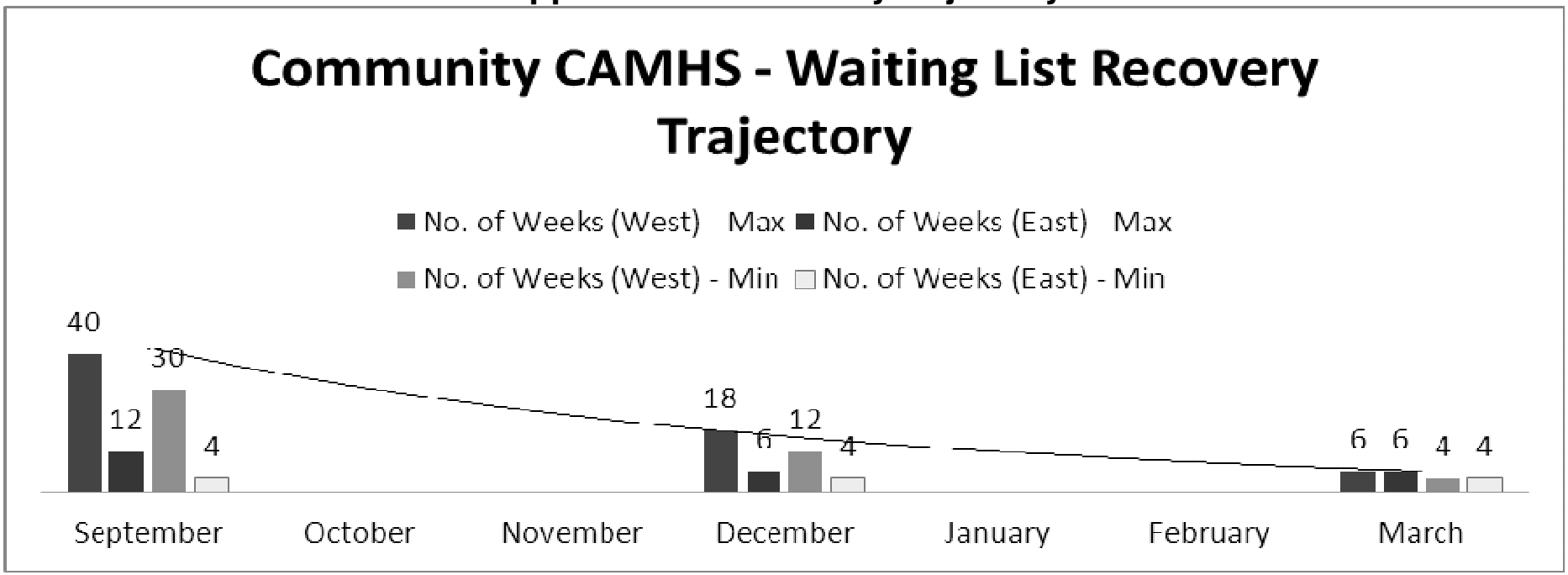
Background documents: None

Appendix 1 Community CAMHS Waiting List Action Plan

Date	Action	By whom	Completed
October 2012	Tier 3 referral guidance criteria circulated to all services and team managers. All families who have been on any CAMHS waiting lists for more than 3 months, will be written to with an 'opt-in' contact to the respective team. All cases waiting up to 3 months will be contacted by telephone, by the local team. All calls and letters will be logged appropriately with closing dates for return contacts. Details of all families who 'opt-out' will be shared with Kent County Council and Medway PCT.	Peter Joyce / All Managers	Mid October
October 2012	Pro-active recruitment to clinical bank list across services to create further capacity within teams – focused on the waiting lists.	All Managers	End of October
On-going	Active attendance of local SPA meetings for joint work, problem solving and clear identification of referral allocations using appropriate referral criteria.	Identified Managers Coterminous with Hubs	End of November
October 2012	Recruitment to local vacancies within identified teams to appropriate grades to ensure function of teams within an effective workforce planning process. To facilitate cost effective resolution of capacity issues of teams.	All Managers and Peter Joyce	End of October
November 2012	Single point of access in each referral base established to inform on going SPA meetings and effective referral allocations.	Identified Local Managers/Clinical Leads	Mid November
On-going	Robust clinical and management supervision in place for all staff to	Managers/Clinical	Audit – End of

	evaluate content and numbers of caseloads and ensue all closed cases are discharged.	Leads	November
November	Structured managers' meetings to reflect progress of action plan and success of reduced waiting lists.	Peter Joyce and Senior Managers	Formal feedback – 30 October
November	Establish regular practice forums between wider Tier 2 and Tier 3 to agree strategic responses to complex referrals, evaluate current pathways and address potential hot spots.	Service Leads	Mid December
November	Performance report submitted to commissioners at monthly performance /contract meeting to evidence where progress has been made in waiting list reduction.	Simone Button	On-going
December	Introduction of CAPA to community teams and effective team based training in the CAPA model to ensure on going tools are in place to ensure robust strategies exist for efficient management and process of referrals within sound clinical governance structure.	Peter Joyce and SPFT Colleagues	End of December 2012 /January 2013

Appendix 2 - Recovery trajectory



*Waiting time representative 1st appointment (assessment and treatment)

The current and planned waiting times (estimated) for east and west Kent are:

	Current longest wait	Current shortest wait	Planned longest wait	Planned shortest wait
East Kent	12	4	6	4
West Kent	40	20	6	4

The recovery trajectory is designed to reduce current waiting times by 50% as of the end of December 2012, and ensure the contracted waiting time of 4 to 6 weeks by the 1ST April 2013.

This waiting list trajectory represents the majority of referrals, but does not representative particular specialist pathways for treatment, which may take shorter or longer waiting periods; case dependant.

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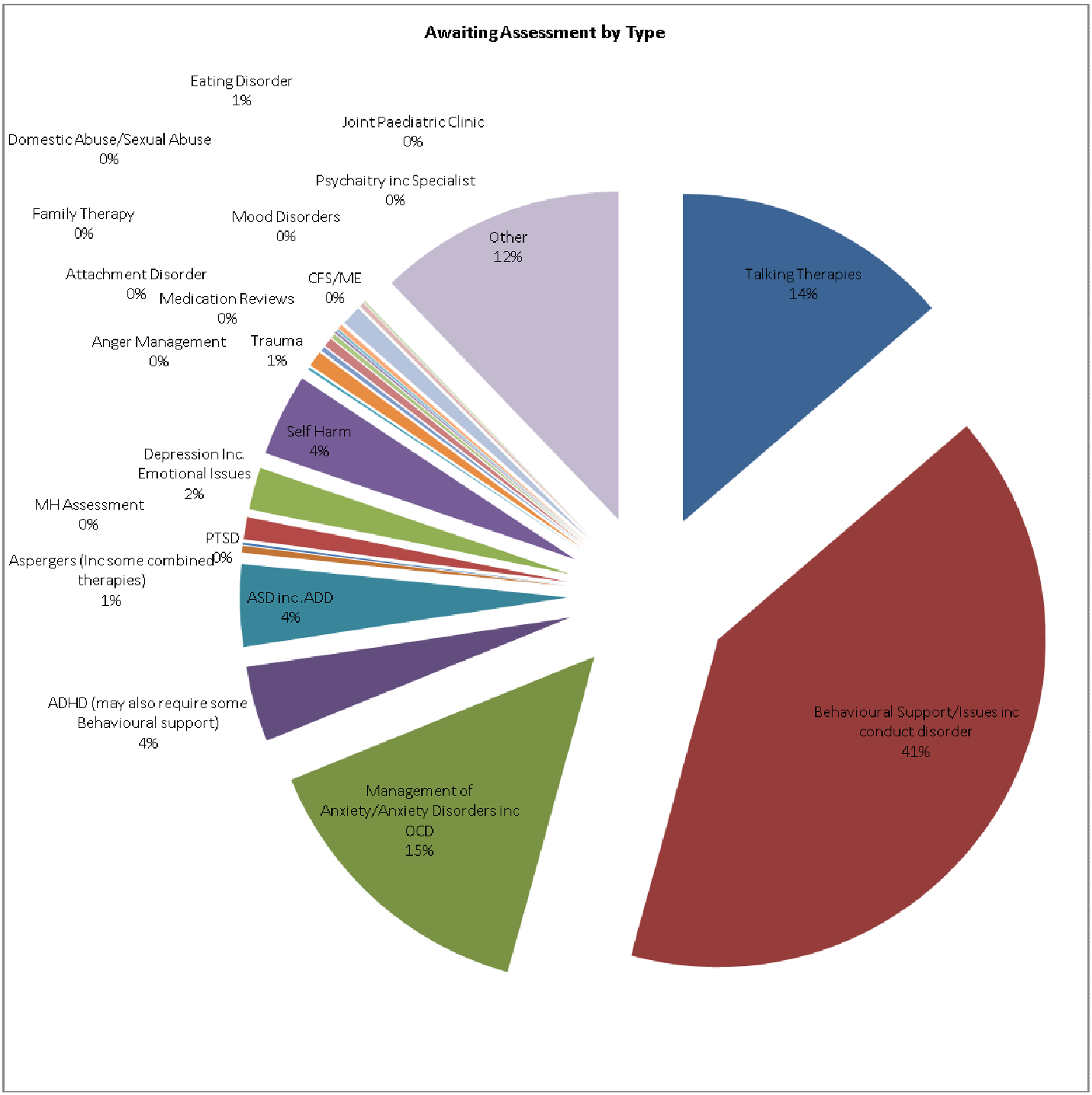
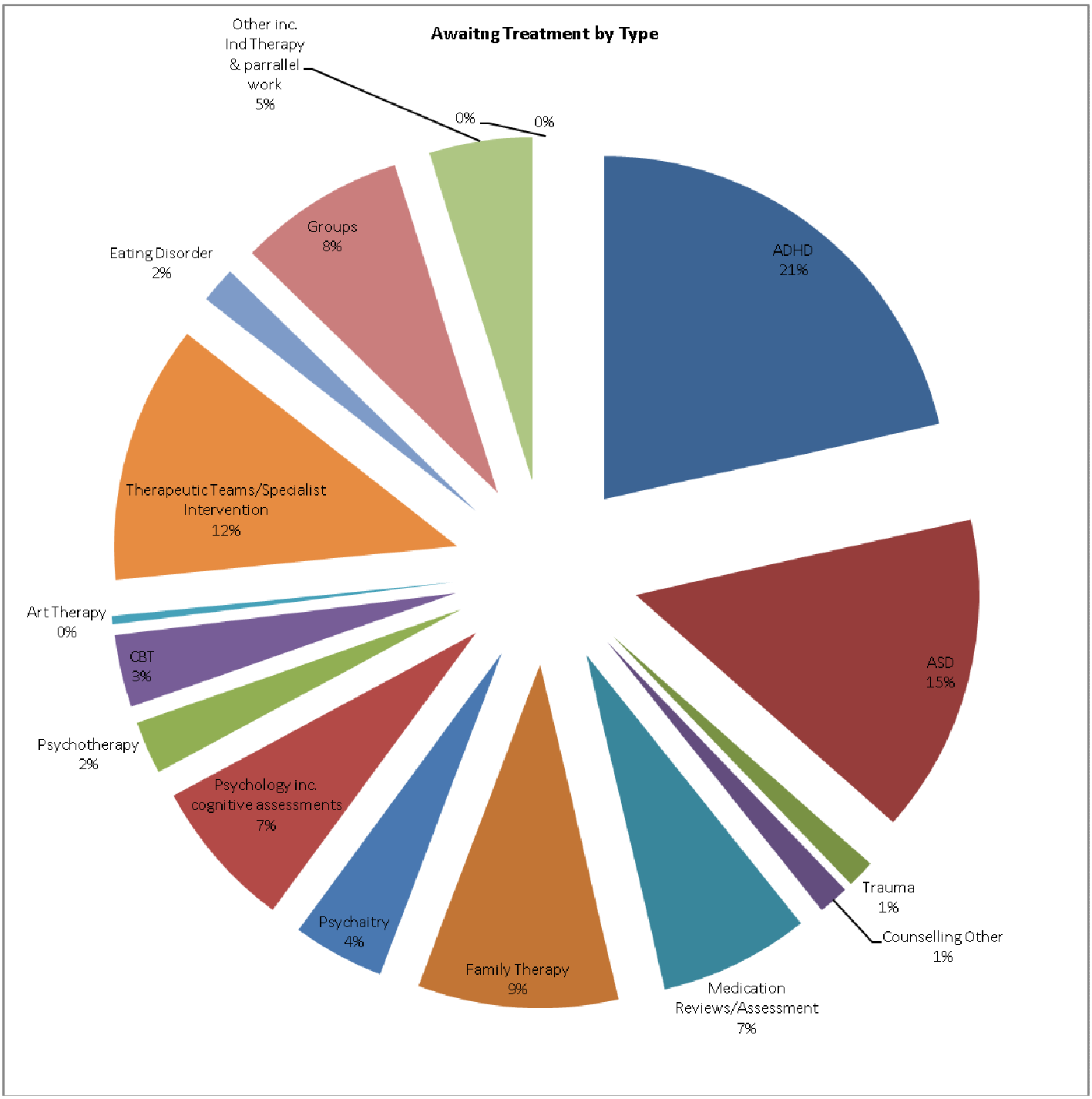
Appendix 3

Assessments Waiting by Type



Treatment Waiting by Type



To: Social Care and Public Health Cabinet Committee – 11 January 2013

By: Graham Gibbens - Cabinet Member for Adult Social Care and Public Health.

Jenny Whittle – Cabinet Member for Specialist Children's Services

Andrew Ireland – Corporate Director for Families & Social Care

Andy Wood – Corporate Director of Finance & Procurement

Subject: **2013/14 Final Draft Budget**

Classification: Unrestricted

Summary: The late announcement of the Local Government Finance arrangements for 2013/14 means that final draft budget could not be available in time to include in this report. The Finance Business Partner will provide a verbal update on the proposals affecting Adult Social Care and Public Health and Specialist Children's Services portfolios for the committee to consider.

1. Introduction

1.1 At the last meeting the Committee was given an update on the consultation on the draft budget launched in September. The consultation closed on 1st November but full analysis of all the responses was not available in time for the committee. A full report was presented to Cabinet on 3rd December and analysis from the independent MORI research and responses to KCC consultation document were published at the same time. These reports are available at http://www.kent.gov.uk/your_council/council_spending/budget_proposals.aspx

1.2 The consultation identified that the council faced estimated reductions in government grant/council tax collection of £28m (excluding Dedicated Schools Grant) and estimated additional spending demands of £32m. Together these required savings and income of £60m to balance the budget

1.3 Since the KCC consultation was launched there have been a number of funding changes announced by central government and details of the new business rates arrangements still to be resolved. These were reported to Cabinet on 3rd December and Cabinet was asked to note the likely overall detrimental impact. Cabinet resolved that the impact would only be quantified after the provisional local government is announced (this was anticipated to be later than previous years and wouldn't be available until close to Christmas).

2. Consultation Responses

2.1 There were a number of issues affecting the Adult Social Care and Public Health and Specialist Children's Services portfolios. in the consultation as reported to Cabinet on 3rd December. Cabinet's response was included in the report and is set out below for Cabinet Committee to comment.

2.2 Adult Social Care

Participants agreed that the current model of service provision is unsustainable due to the ageing population and reduced funding. Views on how to tackle this varied. Some felt that individuals should pay more towards their care. Others thought local communities could do more to help. All participants agreed that people should be supported to remain in their own homes, but did not think this should be funded through increased council tax. Adult social care was identified as most in need of protection from savings during the MORI workshops and was also the third least favourable area for savings in the online survey. Some respondents were concerned that proposals to make savings through transformation could result in diminished services to vulnerable people.

2.2.1 Cabinet are very pleased that participants recognised that the current model of providing adult social care must change. In order to protect these vital services, savings of the magnitude required can only be delivered through fundamentally redesigning how adult social care is delivered. The Adults Transformation Programme will deliver significant savings in 2013/14 and improve outcomes through allowing staff to focus more of their time on productive outcomes and ensuring we provide care that is best suited to individual's needs and circumstance to help them remain independent as long as possible. The Transformation Programme will also deliver savings through better procurement and improved partnership with the NHS and other agencies involved in social care. This is not about cutting services and Cabinet will be including more information about how we intend to go about delivering savings when the final draft budget proposals for 2013/14 are published in a few weeks. Cabinet recognises that we need to explain more clearly what the Transformation Programme aims to achieve in order to allay concerns about service cuts.

2.2.2 In order to ensure a stable and sustainable future for adult social care in Kent, and to mitigate the risk of reductions to front line services, the first phase of the Adult Social Care Transformation Programme will focus on four main areas:

i) Transforming the care pathway: giving as many people as possible the opportunity to receive services that enable them to be independent for as long as they can be. We expect our focus on early intervention support will reduce long term care needs/costs. Examples of this are:
   a. Enablement: significantly increasing the number of people who receive short-term intensive services that support people to learn, or re-learn,

everyday skills and have confidence to complete daily living tasks themselves. These types of services can be suitable for people upon discharge from hospital, after illness or accident of other life changing events. People who have Enablement usually find that, afterwards, they can manage very well on their own or with a very low level of support.

b. Telecare: broadening the range and use of equipment and technology currently used so that it supports even more people to live safely and independently in their homes, thereby reducing the number of admissions to costly residential care.

ii) Increasing our performance: reducing the amount of time spent on processes, paperwork and systems so that we work as efficiently and effectively as possible. This will increase how quickly people access support and make better use of staff time.

iii) Strategic commissioning and procurement: making sure that we maximise value in all that we commission and procure. This will keep prices affordable for users of our services as well as the Council. We will look at ways to use our buying power to bulk buy whilst understanding the social care market and ensuring businesses are not put at risk.

iv) Investment: utilising ring-fenced NHS social care funding in a range of services that will reduce the number of people requiring ongoing support from social services and improve health outcomes. We will use this money to develop a range of new services that will provide additional support to carers, prevent social isolation, avoid hospital admissions and ensure safe and timely hospital discharge.

2.2.3 Focussing on the above in the first phase of the programme (18-24 months) aims to ensure we have a robust foundation in which to manage further transformation such as integration with health.

2.2.4 One of the central aims of the Adults Transformation Programme is to improve preventative action to help people avoid, delay or minimise their need for care, and Cabinet welcomes the support for this approach. We are also exploring how communities can help support elderly and disabled people.

2.2.5 KCC is lobbying Government to implement the Dilnot Commission's recommendations on the funding of adult social care by 2015, including the lifetime cap on care costs and increased means test level. A properly funded system for adult social care will relieve the increasing pressure on Local Authorities in the future.

2.3 Children's Social Care

Participants felt that in order to help look after the most vulnerable children, KCC should continue to be responsible for Children's Social Care. They were not able to identify many ways of saving money, and tended to think that there should be more investment in services. Participants were in favour of early

intervention and prevention activity to stop problems escalating and the need for expensive interventions. Children's social care was rated as the least acceptable area for savings in the online survey, with some respondents concerned that proposed budget cuts could leave vulnerable children at risk. However, participants at the MORI workshops did not agree that council tax should be raised to increase funding for these services. Some participants recognised the need to encourage more people to adopt or foster children.

2.3.1 Cabinet acknowledges that the consultation has shown unease about the scale of the potential savings to Children's Social Care. Although there have been significant improvements in Children's Social Care over the last two years, this has come at the price of £23m of additional investment and Cabinet recognises that there is still much work to do to get long term value from this investment.

2.3.2 The transformation of Children's Social Care aims to shift the emphasis from high-cost reactive work to a preventative approach, while at the same time making necessary reductions in spend. It may take a longer period of time for the emphasis to shift and for the investment in early intervention and prevention to pay off. Subsequently, Cabinet will reconsider whether the savings proposed for Children's Social Care next year strike an appropriate balance between the need to reduce costs now and allowing the long-term benefits of a preventative approach to develop. Cabinet's revised plans will be set out in the final draft budget due to be published in a few weeks.

2.3.3 Cabinet agrees entirely with the MORI participants' views that we must do more to improve the process of adoption and fostering. This will help us return children to a stable family environment as soon as possible, which will deliver longer-term reductions in care costs and provide better outcomes for these children. Kent's Looked After Children Strategy explains how we will achieve this. KCC has already seen improvements in the adoption service through working with Coram to improve and streamline the process.

2.4 Children's Services

Participants felt that Children's Services needed the oversight of KCC and did not want to see a reduction in the quality or access to services. There was no support for an increase to council tax but participants were prepared to accept some reduction in cost through increased parental responsibility and greater input from community organisations. Children's Centres was chosen as the second least acceptable area for savings in the online survey, although we have some concerns that the results may have been skewed by a local campaign. Participants felt that employment and careers advice for young people might be better achieved by different external agencies, instead of the CXK service commissioned by KCC.

2.4.1 MORI participants said that each child and their family are unique. Cabinet agrees, and our aim is that families should receive tailored support from an integrated team of professionals including from KCC and our partners. One example of where KCC is putting this approach into action is

the Troubled Families initiative, which will improve outcomes for Kent's highest need families, reduce costs and enhance the way we work and commission together.

2.4.2 Children's Centres provide an important and valued service. Currently KCC has a large number of Children's Centres operating across the county (97). 20 of these are located in the 20% most disadvantaged wards in Kent, and 53 in the 30% most disadvantaged areas. 62 of the centres are located on school sites. 21 have attached on site nurseries, with partnership agreements with a further 25 nurseries which are actively supporting the free childcare places for all three and four year olds, as well as the new 'Free for Two' agenda.

2.4.3 Between October 2011 and September 2012, 42,480 children were active registered users at a centre in Kent, this equates to approximately 40% of the County's 0-4 year olds. Cabinet needs to ensure that the centres are reaching the families that need help and supporting the preventative agenda. Review work is underway to find the most appropriate operating model for Children's Centres, which includes looking at integration with other services and their geographical distribution. This review activity will ensure that we better target Children's Centres activity to those who need it most in the future, and supports other Kent priorities such as Children's Social Care and the Troubled Families initiative.

2.4.4 In addition to looking at operating and geographical models, Cabinet are also considering how Children's Centres could deliver improved value for money and further efficiencies through income generation, standardised core staffing structures, reallocation of funding based on needs and economies of scale through more effective commissioning.

2.4.5 People who responded to the budget consultation felt that supporting young people into employment is important. This is a priority for KCC and there is a great deal of activity going on including the Kent Jobs for Kent's Young People campaign which has already secured over 100 apprenticeship pledges and the online careers guidance portal Kent choices 4 U which is being used by 83% of young people who are in the transition to 16+ learning. Cabinet acknowledges participants' concerns about the effectiveness of the current contract for employment and careers advice. Cabinet agrees that we need to find a more effective way to provide specialist careers advice to vulnerable young people and are developing options to achieve this within the proposed budget.

3. Medium Term Financial Plan and Budget Book

3.1 The published Medium Term Financial Plan (MTFP) 2012/15 set out the main changes between 2011/12 and 2012/13 budget for each portfolio. We did not produce detailed plans for individual portfolios for future years as recent experience has shown that subsequent changes make these plans unrealistic. The published plan included an overall 3 year plan for the whole council setting out the anticipated funding reductions and additional spending

demands and the broad areas where the authority anticipated identifying savings to balance the budget. The 2012/13 plan for the Adult Social Care and Public Health and Specialist Children's Services portfolios is included as appendix 1.

3.2 The Budget Book continued to be produced in an A to Z service format rather than portfolio basis. This change was introduced in 2011/12 and has generally been well received as it focuses attention on the services KCC provides rather than how the authority is organised. In 2012/13 we introduced detailed variation statements for each line in the A to Z to explain movements between 2011/12 and 2012/13. The final version of the Budget Book published in March included details of individual directorate/service unit budgets and an extract of the A to Z for each portfolio. This extract of the 2012/13 A to Z for the Adult Social Care and Public Health and Specialist Children's Services portfolios is included as appendix 2.

3.3 The Budget Book included a revised presentation of the capital programme. This set out the overall capital investments under each portfolio and how expenditure in 2012/15 was planned to be funded. This revised presentation provided a more appropriate focus on overall spending and funding rather than concentrating on the phasing of expenditure. The 2012/15 investment plan for the Adult Social Care and Public Health and Specialist Children's Services portfolios is included as appendix 3.

3.4 The final draft MTFP and Budget Book 2013/14 adopts these same principles. In order to be compatible with the spending Review we have only included a 2 year overall plan for the whole council (it would not be appropriate to pre-judge the outcome of the forth coming spending review). The MTFP also includes more detail on the national and local economic context and revised revenue and capital budget strategies.

3.5 The timing of the local government provisional settlement means that Committees have had little opportunity to consider the final draft proposals in advance of the meeting. Committees are invited to consider whether individual Informal member Groups (IMGs) should be convened to consider the draft proposals prior to final consideration at County Council on 14th February. The final proposals have been launched with a very short period for comments.

4. Recommendations

4.1 Members are asked to:

(a) **NOTE** the late announcement of the provisional local government finance settlement and the impact on budget timetable

(b) **COMMENT** on the issues affecting the Adult Social Care and Public Health and Specialist Children's Services portfolios raised in consultation and Cabinet's response

(c) **CONSIDER** convening an IMG to consider the final budget proposals affecting the Adult Social Care and Public Health and Specialist Children's Services portfolios in advance of County Council meeting on 14th February

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Background Documents: None

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Appendix 1

Adult Social Care and Public Health Portfolio
Revenue Budget

		New / Existing	2012/13 £'000
Base Budget			**317,434**
Base Budget Adjustments - Internal			**-4,040**
	Transfer of Learning Disability and Health Reform Grant to be held centrally		34,768
Base Budget Adjustments- External			**34,768**
Total Base Adjustments			**30,728**
Revised Base Budget			**348,162**
ADDITIONAL SPENDING PRESSURES			
Pay:			
All	Staff Travel	N	160
All	Employers National Insurance increase	N	115
All	Kent Scheme Pay Award	N	725
All	Total Contribution Pay	N	365
			1,365
Prices:			
All	Transport	E	55
All	Social Care Provision	N	3,091
All	Other	E	61
			3,207
Unavoidable Government/Legislative Pressures:			
Various	Learning Disability Transfer and Health Reform Grant - increase in expenditure	E	859
Various	Net pressures funded from NHS support for Social Care grant	N	5,406
			6,265
Demand/Demographic Led:			
Older Persons	Older People	E	-287
Learning Disability	Learning Disability - Residential	E	1,082
Learning Disability	Learning Disability - Community Services	E	2,989
Physical Disability	Physical Disability - Residential	E	311
Physical Disability	Physical Disability - Community Services	E	2,021
Mental Health	Mental Health	E	559
			6,675
Total Pressures			**17,512**
SAVINGS AND INCOME:			
Income Generation:			
All	Income increase in-line with Benefits Uplift	E	-2,854
	Increase in Blue Badge charges	N	-170
All	NHS support for Social Care	N	-15,656

Appendix 1

Adult Social Care and Public Health Portfolio
Revenue Budget

		New / Existing	2012/13 £'000
All	FYE of Increase Charging - non residential	E	-1,477
			-20,157
Savings and Mitigations:			
Identified in published 2010/13 MTP:			
	Fall out of early Retirement Costs	E	-19
	Streamline back office support functions	E	-452
			-471
Efficiency Savings:			
All	Essential/Lease user	E	-21
Procurement			
All	Review of Community Service Procurement	E	-2,132
Management Structures			
	Support Services	E	-121
Learning Disability	Day Services Review - LD	E	-88
Access & Assessment			
	Hospital Team Review	E	-75
Mental Health	Mental Health Management	E	-50
	Co-ordination Managers	E	-50
Various	Agency Staff	E	-115
Learning Disability & Physical Disability	Review of LD and PD Residential and Supported Accommodation procurement	E	-3,393
			-6,045
Service Reforms:			
Older Persons	Consistent application of fair access to Care Services policy	E	-500
Older Persons	Encouraging Self Funders of Residential Care to seek independent financial advice	E	-250
Older Persons	Older Persons Strategy	E	-1,200
Older Persons	Review of In-house services - OP	E	-150
Learning Disability	Review of In-house services - LD	E	-550
Physical Disability	Review of In-house services - PD	E	-25
Public Health	Rationalise Healthwatch Programme	E	-32
All	Consistent application of client transport policy	E	-290
			-2,997
Total Savings and Mitigations			**-9,513**
Total Savings and Income			**-29,670**
Budget controlled by this portfolio			**336,004**

Appendix 1

Specialist Children's Services Portfolio
Revenue Budget

		New / Existing	2012/13 £'000
Base Budget			**102,298**
Base Budget Adjustments - Internal			**-3,745**
Base Budget Adjustments- External			**36,447**
Total Base Adjustments			**32,702**
Revised Base Budget			**135,000**
ADDITIONAL SPENDING PRESSURES			
Pay:			
All	Staff Travel	N	75
All	Employers National Insurance increase	N	103
All	Kent Scheme Pay Award	N	589
All	Total Contribution Pay	N	351
			1,118
Prices:			
All	Transport	E	47
SCS	Social Care Provision	E	502
C&P	Other (inc Legal)	E	8
			557
Unavoidable Government/Legislative Pressures:			
Asylum	Asylum	N	800
Early Years	Increase Early Years education for 2 year old	N	860
			1,660
Demand/Demographic Led:			
Legal	Legal Services	N	1,621
Residential	Residential Care	N	2,568
Fostering	Fostering	N	4,091
Leaving Care	Leaving Care	N	829
Adoption	Adoption	N	1,050
Fostering and Support Services	Kinship & FGC	N	630
Social Care Staffing	Social Care Staffing	N	2,960
Safeguarding	Safeguarding	N	298
			14,047
Service Strategies & Improvements:			
Social Care Staffing	Workforce Strategy	N	2,284
Social Care Staffing	Social Care staffing - additional posts	N	1,263
Preventative Services	Investment in Prevention (LAC) Strategy	N	2,750
			6,297
Total Pressures			**23,679**

Appendix 1

Specialist Children's Services Portfolio
Revenue Budget

		New / Existing	2012/13 £'000
SAVINGS AND INCOME:			
Savings and Mitigations:			
Removal of one-off funding			
Children's Centres	Review of Early Years and Childcare/EIG Transitional protection	E	-893
			-893
New Efficiency Savings:			
All	Reduction in staff travel	E	-3
All	Management Structures	E	-48
Preventative Services	Social care procurement	E	-100
Residential and Fostering	Savings from investment in Prevention services (LAC Strategy)	E	-3,117
Directorate Mgmt and Support	Commissioning (staffing)	E	-22
			-3,290
Service Reforms:			
Early Years	Review of Early Years and Childcare	N	-1,145
			-1,145
Total Savings and Mitigations			**-5,328**
Total Savings and Income			**-5,328**
Budget controlled by this portfolio			**153,351**

Appendix 2 - Portfolio Revenue Budgets

Adult Social Care and Public Health

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
			Adults and Older People								
			Direct Payments								
1	9,672	ASC&PH	Learning Disability	0	11,573	11,573	-547	11,026	0	11,026	Approximately 1000 clients are expected to be receiving an on-going direct payment. These people have been assessed as being eligible for social care support, but have chosen to arrange and pay for their own care and support services instead of receiving them directly from the local authority. There will also be a number of one-off direct payments made during the year for such things as items of equipment and respite care
2	732	ASC&PH	Mental Health	0	995	995	0	995	0	995	Approximately 200 clients are expected to be receiving an on-going direct payment; there will also be a number of one-off direct payments made during the year.
3	5,494	ASC&PH	Older People	0	7,008	7,008	-787	6,221	0	6,221	Around 1000 clients will be receiving an on-going direct payment; there will also be a number of one-off direct payments made during the year.
4	7,895	ASC&PH	Physical Disability	0	9,561	9,561	-374	9,187	0	9,187	Around 1000 clients are expected to be receiving an on-going direct payment ; there will also be a number of one-off direct payments made during the year.
			Domiciliary Care								
5	5,642	ASC&PH	Learning Disability	2,639	3,630	6,269	-1,187	5,082	0	5,082	Domiciliary care provided by the independent sector supporting approximately 420 people to live at home. In addition this service provides: support to 120 people through the independent living scheme and other domiciliary support
6	598	ASC&PH	Mental Health	0	532	532	-80	452	0	452	Services provided through the independent sector supporting people to live at home

Appendix 2 - Portfolio Revenue Budgets

Adult Social Care and Public Health

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
7	34,485	ASC&PH	Older People	6,197	37,639	43,836	-12,033	31,803	0	31,803	Domiciliary care provided by the independent sector supporting nearly 5,000 people to live at home. In addition this service provides: - the Kent Enablement at Home Service which provides intensive short term support/enablement to people to allow them to regain or extend their independent living skills; and a number of small contracts for services primarily with Health, including the night sitting service, recuperative care and rapid response.
8	7,129	ASC&PH	Physical Disability	269	7,291	7,560	-576	6,984	0	6,984	Domiciliary care provided by the independent sector supporting approximately 950 people to live at home. This service also provides other domiciliary support (KCC and Independent Living Scheme).
			Nursing and Residential Care								
9	70,390	ASC&PH	Learning Disability	2,036	74,128	76,164	-6,459	69,705	0	69,705	620 clients are provided services through the independent sector. In addition, this service provides: permanent residential care for preserved rights clients through the independent sector and 88 respite beds across various KCC sites.
10	5,924	ASC&PH	Mental Health	0	6,929	6,929	-875	6,054	0	6,054	10,300 weeks of residential care provided through the independent sector. This service also provides approximately 3,000 weeks of permanent residential care for preserved rights clients through the independent sector.
11	23,477	ASC&PH	Older People - Nursing	0	44,812	44,812	-22,674	22,138	0	22,138	Around 1,500 clients provided this service through the independent sector. This service administers the payment of the health element of the nursing cost and reclaims this from PCT's
12	50,605	ASC&PH	Older People - Residential	10,991	74,358	85,349	-36,494	48,855	0	48,855	Approximately 2,900 clients on average provided through the independent sector. In addition, this service provides: permanent residential care for preserved rights clients provided through the independent sector. In-house this provides 201 residential care beds and 60 nursing care beds.

Appendix 2 - Portfolio Revenue Budgets

Adult Social Care and Public Health

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
13	11,567	ASC&PH	Physical Disability	0	13,813	13,813	-1,969	11,844	0	11,844	Approximately 260 clients provided this service through the independent sector.
			Supported Accommodation								
14	27,709	ASC&PH	Learning Disability	462	32,636	33,098	-3,694	29,404	0	29,404	Services provided through the independent sector for approximately 620 people in supported accommodation/supported living.
15	1,359	ASC&PH	Physical Disability/Mental Health	0	2,552	2,552	-274	2,278	0	2,278	Services provided through the independent sector in respect of individuals in supported living and supported accommodation
			Other Services for Adults and Older People								
16	13,742	ASC&PH	Contributions to Voluntary Organisations	0	16,044	16,044	-902	15,142	0	15,142	Payments to voluntary organisations for a range of preventative services supporting approximately 6,000 people.
			Day Care								
17	13,114	ASC&PH	Learning Disability	6,767	6,344	13,111	-503	12,608	0	12,608	Day care/day services provided both in the independent sector and in-house
18	3,769	ASC&PH	Older People	1,124	2,329	3,453	-195	3,258	0	3,258	Day care/day services provided both in the independent sector and in-house
19	1,581	ASC&PH	Physical Disability / Mental Health	0	1,565	1,565	-38	1,527	0	1,527	Day care/day services provided both in the independent sector and in-house
20	5,852	ASC&PH	Other Adult Services	1,049	16,886	17,935	-23,780	-5,845	0	-5,845	A range of other services including: - approximately 240,000 home delivered hot meals; Occupational Therapy & Sensory Disability services working in partnership with Health, Hi Kent and Kent Association for the Blind to provide approximately 56,000 items of equipment. Community outreach support to clients with mental health problems; providing support for people with a disability to fund and keep work; collaborating with health on the delivery of Telehealth and Telecare services.
21	565	ASC&PH	Safeguarding	469	340	809	-236	573	0	573	A multi agency partnership/framework to ensure a coherent policy for the protection of vulnerable adults

Appendix 2 - Portfolio Revenue Budgets

Adult Social Care and Public Health

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
22	59	ASC&PH	Public Health (incl. Local Involvement Network)	0	84	84	-57	27	0	27	Health Promotion and the 'Mobile House' project which delivers discreet lifestyle messages to promote behavioural change. Funding for the Kent LINk and payment to an independent company whose role it is to help the work of the Kent LINk in improving health and social care services
23	**301,360**		**Total Direct Services to the Public**	**32,003**	**371,049**	**403,052**	**-113,734**	**289,318**	**0**	**289,318**	
			Assessment Services								
24	37,792	ASC&PH	Adult's Social Care Staffing	37,936	2,152	40,088	-1,981	38,107	0	38,107	Social care staffing providing assessment of community care needs undertaken by Case Managers and Mental Health Social Workers
25	**37,792**		**Total Assessment Services**	**37,936**	**2,152**	**40,088**	**-1,981**	**38,107**	**0**	**38,107**	

Appendix 2 - Portfolio Revenue Budgets

Adult Social Care and Public Health

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
			Management, Support Services and Overheads								
26	9,010	ASC&PH	Directorate Management & Support - Families and Social Care (FSC)	7,401	1,663	9,064	-485	8,579	0	8,579	
27	**9,010**		**Total Management, Support Services and Overheads**	**7,401**	**1,663**	**9,064**	**-485**	**8,579**	**0**	**8,579**	Overheads no longer sit with the Directorates so 2012/13 costs are not directly comparable with 2011/12. They have been stripped out, slimmed down and transferred to the centre.
28	348,162		**TOTAL**	77,340	374,864	452,204	-116,200	336,004	0	336,004	

Appendix 2 - Portfolio Revenue Budgets

Specialist Children's Services

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
			Children's Services								
			Education and Personal								
1	19,222	SCS	Children's Centres	14,524	3,255	17,779	0	17,779	0	17,779	97 children's centres delivering support and advice to families
2	4,195	SCS	Early Years and Childcare	1,366	2,533	3,899	-107	3,792	0	3,792	Provision of advice, support, challenge and training to over 1,100 childcare providers and 1,600 childminders in the private and voluntary sector and staff in local authority maintained schools with nursery and reception classes
3	916	SCS	Early Years Education	0	41,276	41,276	0	41,276	-39,500	1,776	Payments made to over 740 PVI providers for up to 15 hours a week of free entitlement places for 3 & 4 year olds (equates to over 9.5 million hours of provision) plus over 325,000 hours of free places for disadvantaged 2 year olds
4	1,928	SCS	Virtual School Kent	1,808	833	2,641	0	2,641	-704	1,937	Supporting approx 1,600 looked after children focussing on their education & health needs
			Social Services								
5	7,096	SCS	Adoption	1,960	6,361	8,321	-49	8,272	0	8,272	Permanent care for Kent children who are unable to live with their birth families. Includes adoption payments & Special Guardianship orders
6	280	SCS	Asylum Seekers	4,508	10,817	15,325	0	15,325	-14,245	1,080	Supporting 700 unaccompanied asylum seekers (225 under 18, 475 over 18)
7	1,367	SCS	Children's Support Services	2,302	178	2,480	-1,043	1,437	0	1,437	Out of hours emergency service and family group conferencing
8	29,953	SCS	Fostering	3,924	29,096	33,020	-237	32,783	0	32,783	Short and medium family based care (including longer term care for older children) for Kent children. Includes payments to related and non related foster carers for 1,150 children and independent fostering agencies for 125 children.

Appendix 2 - Portfolio Revenue Budgets

Specialist Children's Services

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
9	4,298	SCS	Leaving Care (formerly 16+ service)	0	5,127	5,127	0	5,127	0	5,127	Supporting children leaving care and ongoing children's services for those aged 16+ still in local authority care, and aftercare service for young people aged 18+. Now excluding residential care and fostering.
10	4,694	SCS	Legal Charges	0	6,315	6,315	0	6,315	0	6,315	Costs for in-house legal support and external legal fees for care proceedings for Specialist Children's Services (previously reflected within the Fostering service)
11	12,538	SCS	Other Preventative Children's Services	3,534	16,005	19,539	-829	18,710	-3,500	15,210	Community based preventative and family support services including day care, direct payments and payments to voluntary organisations
12	9,902	SCS	Residential Children's Services	2,386	11,511	13,897	-2,149	11,748	0	11,748	In house and independent sector residential care for 65 children (both looked after and non looked after children, including those with a disability).
13	3,416	SCS	Safeguarding	3,886	449	4,335	-316	4,019	0	4,019	Performance management of services for vulnerable children in Kent
14	**99,805**		**Total Direct Services to the Public**	**40,198**	**133,756**	**173,954**	**-4,730**	**169,224**	**-57,949**	**111,275**	
			Assessment Services								
15	30,475	SCS	Children's Social Care Staffing	36,539	1,746	38,285	-819	37,466	-66	37,400	Social Care staffing providing assessment of children & families needs and ongoing support to looked after children
16	**30,475**		**Total Assessment Services**	**36,539**	**1,746**	**38,285**	**-819**	**37,466**	**-66**	**37,400**	
			Management, Support Services and Overheads								

Appendix 2 - Portfolio Revenue Budgets

Specialist Children's Services

	2011/12 Revised Base	Portfolio	Service	2012/13 Approved Budget							
	Net Cost £000s			Staffing £000s	Non staffing £000s	Gross Expenditure £000s	Service Income £000s	Net Expenditure £000s	Govt. Grants £000s	Net Cost £000s	Affordable Activity
17	4,720	SCS	Directorate Management & Support - Families and Social Care (FSC)	1,941	3,697	5,638	-196	5,442	-766	4,676	
18	**4,720**		**Total Management, Support Services and Overheads**	**1,941**	**3,697**	**5,638**	**-196**	**5,442**	**-766**	**4,676**	Overheads no longer sit with the Directorates so 2012/13 costs are not directly comparable with 2011/12. They have been stripped out, slimmed down and transferred to the centre.
19	135,000		**TOTAL**	78,678	139,199	217,877	-5,745	212,132	-58,781	153,351	

ADULTS SOCIAL CARE & PUBLIC HEALTH

SECTION 3 - CAPITAL INVESTMENT PLANS 2012/13 TO 2014/15

Row ref				2012/15 Funded By:								
		Three year budget		Borrowing	PEF2	Grants	Dev Contrs	Other External Funding	Revenue & Renewals	Capital Receipts	PFI	
		£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
	ROLLING PROGRAMMES											
1	Asset Modernisation	**15**		14						1		
2	*Home Support Fund*	**3,414**				3,414						
3	**Total Rolling Programmes**	**3,429**		**14**		**3,414**				**1**		
		Total cost of scheme	***Previous Spend***	**Borrowing**	**PEF2**	**Grants**	**Dev Contrs**	**Other External Funding**	**Revenue & Renewals**	**Capital Receipts**	**PFI**	***Later Years***
		£'000	***£'000***	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	***£'000***
	INDIVIDUAL PROJECTS											
	Kent Strategy for Services for Older People (OP):											
4	*OP Strategy - Specialist Care Facilities*	**5,088**	*224*	332	1,082		76			3,374		
5	OP Strategy - Trinity Centre, Dartford	**1,000**	*1*							999		
	Kent Strategy for Services for People with Learning Difficulties/Physical Disabilities:											
6	*Community Care Centre - Thameside Eastern Quarry/Ebbsfleet*	**1,418**					1,365			53		
7	*Learning Disability Good Day Programme*	**6,823**	*1,260*	104	5,154					305		
	Active Care/Active Lives Strategy:											
8	PFI - Excellent Homes for All - Development of new Social Housing for vulnerable people in Kent	**70,420**									70,420	
	Developing Innovative and Modernising Services:											
9	*Capital Grant - IT Related Projects*	**3,518**	*1,796*			1,722						
10	Public Access Development	**1,237**	*487*	487	43	150				70		
11	**Total Individual Projects**	**89,504**	***3,768***	**923**	**6,279**	**1,872**	**1,441**			**4,801**	**70,420**	
12	**TOTAL CASH LIMIT**	**92,933**	***3,768***	**937**	**6,279**	**5,286**	**1,441**			**4,802**	**70,420**	

Italic font: these are projects that are relying on significant elements of unsecured funding and will only go ahead if the funding is achieved

SPECIALIST CHILDREN'S SERVICES

SECTION 3 - CAPITAL INVESTMENT PLANS 2012/13 TO 2014/15

Row ref				2012/15 Funded By:								
		Total cost of scheme	***Previous Spend***	**Borrowing**	**PEF2**	**Grants**	**Dev Contrs**	**Other External Funding**	**Revenue & Renewals**	**Capital Receipts**	**PFI**	***Later Years***
		£'000	***£'000***	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	***£'000***
	INDIVIDUAL PROJECTS											
1	Multi Agency Specialist Hubs (Children Development Centres)	**14,917**	*14,912*	2				3				
2	Service Redesign	**251**	*35*	216								
3	**Total Individual Projects**	**15,168**	***14,947***	**218**				**3**				
4	**TOTAL CASH LIMIT**	**15,168**	***14,947***	**218**				**3**				

Italic font: these are projects that are relying on significant elements of unsecured funding and will only go ahead if the funding is achieved

By: Graham, Gibbens, Cabinet Member for Adult Social Care and Public Health.

Jenny Whittle, Cabinet Member for Specialist Children's Services.

Andrew Ireland, Corporate Director – Families and Social Care.

To: Social Care and Public Health Cabinet Committee – 11 January 2013

Subject: Business Planning 2013/14 – Draft Plans

Classification: Unrestricted

Purpose: Following the development of the business planning headline priorities in November 2012, Directors and Heads of Service have built on the feedback received from Cabinet Committees to develop substantive draft business plans for 2013/14.

This year the emphasis has been on reducing the burden of business planning with a lighter touch process, whilst increasing the consistency and synergy between business planning, and both the performance management dashboards and divisional risk registers which underpin the business plan actions.

The Social Care and Public Health Cabinet Committee is asked to CONSIDER and COMMENT on the draft plans, ahead of the Cabinet key decision to approve business plans in March 2013.

1. Background

1.1 A pre-requisite to delivering key organisational priorities, both in the medium and long-term, is an effective business plan. Offering a clear focus on the delivery of agreed strategic outcomes through day-to-day activity.

1.2 During the November cycle of Cabinet Committees meetings, each Committee was given the opportunity to discuss and comment on the high-level 'headline priorities' for each division. This feedback was considered and reflected as early substantive draft plans were developed, to ensure that the headlines evolved into more detailed activity, with known legislative, policy and financial constraints taken into account.

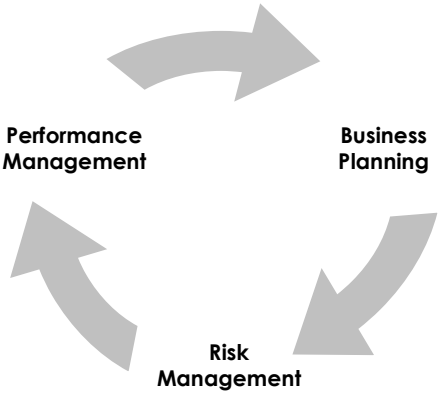
1.3 The emphasis for the 2013/14 draft business plans is identifying clear, tangible actions, ensuring that all activity is Specific, Measurable, Attainable, Realistic and Time bound (SMART). Actions are underpinned

by milestones to check activity progress and further complemented by meaningful Key Performance Indicators (KPIs) and Activity Indicators that enable the organisation to monitor and manage performance, to demonstrate progress against the delivery of Bold Steps for Kent. High level risks relating to the delivery of the actions are set out in the business plan, supported by detailed Divisional and Directorate Risk Registers.

1.4 The draft plans are still at an early stage of development, with further refinement over the coming months before approval in March 2013. The Policy and Strategic Relationships team has been supporting Directors and Directorate Management Teams (DMT) to develop their draft plans as part of ongoing, informal Quality Assurance process, to help embed the revised business planning process.

2. Business Planning, Performance Management and Risk

2.1 It is important that the business planning process closely complements and supports the work already underway to improve the quality and consistency of performance and risk management across the organisation. As such, to help reduce the burden of business planning development on the directorates, the draft business plans draw on the existing work to prepare the Directorate Performance Dashboard and Divisional Risk Registers. This helps to reduce the duplication of effort, and enhances the relationship and synergies between planning, risk and performance. This will enable business planning to become a meaningful tool to influence day to day business whilst ensuring that KCC's strategic priorities are met. Cabinet Committees play an important role in providing oversight and assurance of these synergies through the bi-annual business plan outturn monitoring process.



2.2 **Performance Management**

All business plans actions are measured against a selection of focused key performance and activity indicators. Keeping all actions SMART will ensure that meaningful management information is developed to support the Performance Dashboards reported to Cabinet Committees on a quarterly basis.

2.3 This year, divisions have taken feedback from Cabinet Committees on Performance Management Dashboards into account when developing their 2013/14 performance measures. The focus has been on being more focused in only selecting KPIs which are the most meaningful and accurate reflection of progress against key priorities. This will allow more concise reporting of performance to Cabinet Committees in the coming year's dashboard. The Social Care and Public Health Cabinet Committee is invited to comment on the draft indicators and discuss which areas of performance they would most like to focus on in 2013/14.

2.4 **Risk Management**

Key risks and mitigating actions faced by each division in delivering their 2013/14 business plans are outlined in Section E of each plan. In addition, the key risks from across Families and Social Care that threaten the achievement of business objectives are listed in the directorate risk register **(Appendix A)**, including mitigating actions. The work to develop the divisional risk register has already been undertaken by the directorates and provide further context to the business planning process and are either:

- more strategic or cross-cutting in nature;
- present a significant directorate-wide risk, or
- present a significant risk to one or more service / unit that could impact on the directorate or KCC as a whole.

3. <u>Business Planning Timetable 2013/14</u>

3.1 Historically, business plans were approved by Cabinet and then potentially called into scrutiny. From 2013/14 business plans will be made as an annual Key Decision, with Cabinet Committees playing a key role in considering and shaping the draft plans prior to approval as part of pre-scrutiny.

3.2 As a result the timetable for the development of business plans has been brought forward so Committees have an earlier opportunity to comment on draft plans. As such, this will be the last opportunity for Cabinet Committees to formally consider draft plans before approval by Cabinet in March 2013.

3.3 The Social Care and Public Health Cabinet Committee is asked to CONSIDER and COMMENT on the draft business plans for the Families and Social Care Directorate, set out in **Appendix B**.

3.4 It is important to note that at this early stage the draft plans are not intended to capture all of the planned activity for the forthcoming year. In addition to this, it is not possible to include detailed financial information, as the 2013/14 budget has not yet been approved by County Council. As

such, the plans have some incomplete sections and will require further development and refinement.

3.5 Following feedback from the Cabinet Committee, the responsible Corporate Directors, Directors and Cabinet Members will further develop and refine the draft plans.

3.6 In February, the plans will be submitted to the Policy and Strategic Relationships team for formal quality assurance, which will focus on ensuring the consistency between plans, in particular cross-cutting links to support transformation programmes and organisational priorities. A letter outlining the quality assurance feedback will be sent to Directors to allow a further opportunity to reflect this before the approval and submission of the final business plans to Cabinet for key decision in March 2013.

3.7 The approved plans will go live and be published online in April 2013.

4. An Iterative Process

4.1 The 2013/14 business plans are the starting point for future development and will be refined and improved each year as part of an iterative annual process. As the plans progress through 2013/14 the synergy between performance, risk and business planning will be emphasised. In turn this will make the 2014/15 business planning easier as processes and reporting are embedded and become more consistent and complementary.

4.2 The new Section G in the plan will help to establish a clear recognition of how different service divisions link with corporate support services to achieve shared objectives across the business. The aim of this is to help effectively plan and manage capacity with limited resources, as well as enabling associations to be identified across the business plans, particularly identifying complementary and conflicting activity, to reduce the limitations of working in silos.

4.3 The findings from the quality assurance and auditing of the business planning process for 2013/14 will be taken into account to update the process for 2014/15. This will include updating any documentation and refreshing the supporting management guide to further aid the effective development of business plans in the future.

5. Recommendations

5.1 The Social Care and Public Health Cabinet Committee is asked to:

a) COMMENT on the draft indicators and discuss which areas of performance they would most like to focus on in 2013/14.
b) NOTE the key headline risks set out in Appendix A.
c) CONSIDER and COMMENT on the draft business plans set out in Appendix B.

Appendices:
Appendix A: Headline Risks Report
Appendix B: Substantive Draft Business Plans

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Background Documents: None

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Families & Social Care Directorate

Risk Register

December 2012

Scoring
Potential Impact (score of 0 to 5) multiplied by likelihood of the event occurring (score of 0 to 5) to give total scores.

	Risk Type (e.g. political, financial, reputational, operational) / Cause or source	Event & Consequence / Implication	Overall Risk Owner (accountable manager)	Controls in place	Current (Residual) Rating	Additional action(s) required	Review Date	Target Rating
1	Organisational. Transformation of adult social care services.	• The Transformation programme will have a significant impact on the Directorate and social care services. Adopting new ways of working and a programme of significant change to achieve better outcomes and delivery of savings. If the transformation programme does not meet targets then this will lead to further pressures on the service and on budgets.	Andrew Ireland/Mark Lobban	• A Transformation plan and governance is in place • Support of Efficiency Partner as part of diagnostics. • Separate risk register and issues log. • Oversight and monitoring by Programme Board, Budget Board and Cabinet.	25	• Review of governance for the Implementation Stage. • Secure an Efficiency Partner	February 2013	16
2	Organisational and Professional/social. Improvement of children's services.	• Children's Improvement Plan to make continuous improvements to services for vulnerable children and young people in Kent.	Andrew Ireland/Mairead MacNeil	• Children's Improvement Plan in place. • New structure of children's services in place. • Central Referral unit set up and functioning. • Improvement programme for the Duty and Initial Assessment Team. • Practice Improvement Programme • Robust Performance Monitoring • Performance framework, operational framework, quality assurance framework and early intervention and prevention strategy in place.	16	• Focus on early intervention and preventative services • Children in care Improvement Plan. • Changes to Adoption and Fostering Services. • Recruitment to permanent Social work and Management vacancies. • OFSTED inspection recently completed – to follow up on any actions required post inspection.	31 March 2013	12
3	Professional/Social Safeguarding-protecting vulnerable children and adults	• The Council must fulfil its statutory obligations to effectively safeguard vulnerable children and adults. Its ability to fulfil this obligation could be affected by the adequacy of its controls, management and operational practices or if demand for its services exceeds its capacity and capability.	Andrew Ireland. Mairead MacNeil/Mark Lobban/Penny Southern/Anne Tidmarsh	• Safeguarding Boards in place for children's and for adult social care services, providing a strategic countywide overview across agencies. • Multi-Agency Public Protection Arrangements. • Quarterly reporting to Directors and Cabinet Members and Annual Report for Members. • Implementation of a Central Duty Service (for SCS) and Central Referral Unit. • Programme of internal and external audits of safeguarding including a peer	16	• Strengthen early intervention/prevention services. • Cross-County file audits • Follow up of Peer Reviews of Safeguarding arrangements. • Audit feedback sessions • Practice improvement programme to strengthen practice across children and families. • On going provision of safeguarding training for the relevant staff. • Recruitment programme to attract and retain high calibre social workers and	31 March 2013	12

	Risk Type (e.g. political, financial, reputational, operational) / Cause or source	Event & Consequence / Implication	Overall Risk Owner (accountable manager)	Controls in place	Current (Residual) Rating	Additional action(s) required	Review Date	Target Rating
				review by Essex County Council. • Mental Capacity Act Arrangements in place. • Extensive staff training • Improvement Plan in SCS.		managers.		
4	Financial risks: Austerity and pressures on public sector funding.	• Public sector finance pressures and the need to achieve significant efficiencies for foreseeable future. • Additional funding pressures could significantly impact on social care services. • Partner organisations and private sector providers also experiencing funding challenges potentially putting joint working at risk.	Andrew Ireland/Michelle Goldsmith.	• Robust financial and activity monitoring regularly reported to DMT • Business plans in place and being produced for 2013/14. • Robust Debt Monitoring • Good links with Health and others in place to maintain partnerships and explore joint service delivery • Transformation programme to ensure best use of available resources. • More efficient use of assistive technology	25	• Continued drive to deliver efficient and effective services through transformation and modernisation agendas. • Continue to work innovatively with partners, including health services, to identify any efficiencies. • Access to Resources Team in place • Developing robust commissioning arrangements. • Building community capacity. • Focus on prevention, enablement and independence for vulnerable adults. • Development of appropriate incentives within the commissioning framework.	31 March 2013	16
5	Operational Health and Social Care Integration	• Major strategic development and change process to develop integrated teams will have a significant impact on ways of working.	Anne Tidmarsh/Penny Southern	• Health and Social Care Integration Partnership board to oversee the integration arrangements. • Reporting and inputting to Health and Well Being boards, Locality boards and clinical commissioning groups. • Project management arrangements in place. • Local HASCIP boards to develop working arrangements including pathfinder Single Points of Access, co-location	12	• Developing agreed information governance arrangements. • Developing a risk stratification tool to better target interventions. • HASCIP board and local arrangements to progress integration work. • Agreeing integrated performance measure and monitoring. • Connectivity of information systems.	31 March 2013	6
6	Legislation Health and Social Care Act 2012.	• Significant implications for the future delivery and provision of social care and health • Abolition of PCT's, emergence of Clinical Commissioning Groups and the transfer of public health functions to Local Authorities will require funding and breaks down the cohesion of locality boundaries with PCT's.	Andrew Ireland/Anne Tidmarsh/Mark Lobban/Penny Sourthern/ Mairead MacNeil.	• Existing partnership working with health which is leading to shared improvements • Effective joint initiatives in place with Health • JSNA to support GP commissioning • Close working at leadership level seeking to build a shared transformation plan.	10	• Continued joint working with Health • KCC activity to prepare for new arrangements including developing Health and Wellbeing Board and working with emerging Clinical Commissioning Groups. • Alignment of the commissioning plans	31 March 2013	6

	Risk Type (e.g. political, financial, reputational, operational) / Cause or source	Event & Consequence / Implication	Overall Risk Owner (accountable manager)	Controls in place	Current (Residual) Rating	Additional action(s) required	Review Date	Target Rating
		• Responding to the new health architecture – for example the Health Commissioning Board		• Maintain close links with commissioners to ensure application of continuing health care and Section 117 arrangements.		for FSC and Clinical Commissioning Groups. Use of the Health and Well Being Strategy • Strategic approach to the development of Kent Health Watch.		
7	Social /financial Increasing Demand for social care services	• Risk that demand will outstrip available resources • Fulfilling statutory obligations and duties become increasingly difficult against rising expectations. • Increased demand due to : -demographic changes in population i.e. more people living longer , more people with dementia and an increase in clients with complex needs. • Austerity potentially leading to more stress, family breakdown and need for support from specialist children's services. • more reliance on informal carers leads to strain on families and individuals	Andrew Irealand/ Anne Tidmarsh/Penny Southern/Mark Lobban.	• Robust reporting and analysis to DMT and Business planning. • Joint planning and commissioning with partners • Contracting and Procurement Controls • Transformation programme. • Early intervention and Preventative services aimed at reducing demand-enablement, fast track minor equipment, short term care with step down and step up support. • Modernisation of older people services • Continue to explore streamlining of roles and functions. • Core monitoring now in place for Members • Continued representation to central government and other agencies regarding the disproportionate number of people in need across the age ranges (children and adults) being placed by other Local Authorities into Kent.	25	• Managing prices: A number of key contracts are coming up for Relet • Review of care ensuring good outcomes linked to effective arrangements for support. • Continued use and development of Assistive Technology (Telecare), • Working to ensure the appropriate number of children in care. • Continue to invest in preventative services through voluntary sector partners. • Adult social care Transformation programme – tracking and monitoring the impact of delivery. • Checking cases to unsure where FSC is approached to take cases on then the individual does "qualify" under the Ordinary Residence guidance.	31 March 2013	16
8	Political/social /citizen Managing and working with the Social Care market.	FSC adult services commissions about 90% of services from outside the Directorate. Many of them from the Private and Voluntary Sector. Although this offers efficiencies and value for money it does mean the Directorate needs the market to be buoyant to achieve best value and to give service users real choice and control Lack of capacity impacts on choice to support the personalisation agenda. Impact on P&V sector if we are contracting a range of	Andrew Ireland/Mark Lobban.	• A strong Strategic Commissioning and Access to Resources function across FSC to ensure KCC gets value for money – whilst maintaining productive relationships with providers. • Regular market mapping and price increase pressure tracking. • Procurement and Contracting Controls. • Commissioning in partnership with key agencies (Health) • Regular meetings with provider and trade organisations. • A risk based approach to monitoring	20	• Working with the Kent Social Care Market to be responsive to the increase in personalisation. • Ensuring market is able to offer choice in the new market conditions opened up by personalisation • A number of key contracts coming up for relet. • Continued review of high cost placements in Learning Disability Services to ensure value for money.	31 March 2013	16

	Risk Type (e.g. political, financial, reputational, operational) / Cause or source	Event & Consequence / Implication	Overall Risk Owner (accountable manager)	Controls in place	Current (Residual) Rating	Additional action(s) required	Review Date	Target Rating
		different services in the community through personal budgets/direct payments creates a level of uncertainty for the P&V sector Develop and promote the Children's social care market to ensure the sufficient supply to meet the needs of children in need and children in care. Reduction in Block Contracts changes ability to exert and influence on the market.		providers. • Reviewing relationships with Voluntary organisations • Commissioning Framework for children's services.				
9	Technological Information Technology	• Need to ensure the information systems are fit for purpose and support business requirements. If information systems are not fit for purpose then it can impact on the business and the delivery of services.	Andrew Ireland/Penny Southern/ Mairead MacNeil	• In adults social care the introduction of pathfinder projects in localities to test the AIS system as an upgrade of the current SWIFT client database. • Systems group is in place to progress and monitor developments. • In specialist children's services the introduction of the new ICS system is being project managed. • An ICS board has been established to oversee the procurement and integration of the new system.	12	• Introduction of the new ICS system will necessitate a period of staff training and data migration. • Issues and risks regarding the new ICS system are dealt with in the Programme Board. • A robust project plan is in place for the delivery process.	31 March 2013	6
10	Citizen/Political/ Technological Information Governance Impact of personalisation and closer joint working	• Partnership working means that client information may be shared with other organisations which may have an implication on information sharing protocols • Risk of staff using unsecured networks as they communicate across agencies. • The success of health and social care integration is dependent on organisations being able to share information across agency boundaries.	Andrew Ireland/Anne Tidmarsh/Penny Southern/Mark Lobban	• Information sharing agreements and protocols for some specific projects are in place. • Organisational policies on IT security and the principles of data protection. • E- Learning training for staff to raise awareness. • Clause in employment contracts requiring compliance with data protection requirements.	12	• All projects need to have information protocols and agreements where information is to be shared across agencies. • Need to raise awareness across staff groups. • Complete the information governance statement of compliance – to be submitted early in 2013.	31 March 2013	6
11	Professional/citizen	Impact of emergency or major business disruption on ability of the Directorate to continue to provide essential service and meet its statutory obligations.	Andrew Ireland/Penny Southern	• Business Continuity Plans in place. • Business continuity planning forms part of the contracting arrangements with private	12	• Business Continuity Risk Assessment identifies actions at Divisional level. • Regular review and update of and	31 March 2013	9

	Risk Type (e.g. political, financial, reputational, operational) / Cause or source	Event & Consequence / Implication	Overall Risk Owner (accountable manager)	Controls in place	Current (Residual) Rating	Additional action(s) required	Review Date	Target Rating
	Emergency and continuity planning			and voluntary sector providers. • Good partnership working arrangements at all levels. • Business Impact Analysis is reviewed at least every 12 months, or when substantive changes in processes and priorities are identified.		continuity plans.		
12	Operational KCC/KMPT partnership agreement	Review of Community Support Services and Approved Mental Health Services to ensure the required quality of services are delivered in KMPT and the wider social care workforce. Failure to meet mental health statutory requirements would have legal, financial and reputational risks for the local Authority.	Penny Southern	• Improved governance and performance monitoring arrangements in place. • Strategic oversight by Members. • Work force review and appointment of safeguarding posts. • Joint supervision policy developed.	16	• Continued work to improve early access to mental health service to reduce the need for crisis intervention. • Training being provided on the Mental Capacity Act	31 March 2013	6
13	Operational Preparation for Legislative Changes	Care and Support Bill - Significant Implications for adult social care services – emphasis on early intervention, prevention and increasing choice and control. Likely to impact on charging – depending on response to the Dilnot Commission. Children and Families Bill expected to be introduced in 2013/14. Likely to impact on children's services – assessments for children with SEN, adoption services. Welfare Reform Act 2012 – major overhaul of the benefits system. Likely to impact on welfare dependent people in Kent and could impact of social care service users.	Andrew Ireland/Michael Thomas -Sam.	• Following progress of the Bill. • Presentation to Members • Consideration given to Dilnot Commission recommendations. • Research and analysis of the implcations. • Working with colleagues in the ELS Directorate to prepare for the changes to the SEN service and impact on commissioning. • Welfare Reform Implementation, Response and Monitoring Plan. • Analysis and research into the potential implications.	16	• To continue to monitor progress of the Bill and the Government response t the Dilnot Commission recommendations on charging for social care. • Further briefings and preparations as the bill progresses. • The principles contained in the Bill to inform the Transformation programme. • Further input to an SEN pathfinder project and development of a "local offer". • Increase awareness of the legislation and potential implications for some service users. • Benefits advisors providing training for staff. Also giving advice and help with appeals for social care clients turned down for benefits.	31 March 2013.	9

Divisional Business Plan 2013-14

Directorate Name: Families and Social Care
Division/Business Unit Name: Older People and Physical Disability
Draft V1.5 (18/12/12)

EXECUTIVE SUMMARY:
Cabinet Portfolio: Graham Gibbens – Cabinet Member for Adult Social Care and Public Health
Responsible Corporate Director: Andrew Ireland
Responsible Director: Anne Tidmarsh
Head(s) of Service: Janice Duff, Mike Powe, Sue Stower, Vinay Sangar, Mary Silverton, Jane Barnes, Caroline Hillen
Gross Expenditure: £272.593m (as at 2012/13)
FTE: 1230.72 (as at 2012/13)

SECTION A: ROLE/PURPOSE OF FUNCTION

This Business Plan is produced at a time of challenge and opportunity for the adult social care sector. The challenge includes delivering excellent services at a time of significant demographic change (with increased demand on services) and a time of financial constraint. The opportunities are through transforming ways of working; greater integration with health services; and promoting the personalisation agenda.

The role and function of social care has been determined by an array of legislation, regulations, directions and local authority circulars some of which date back to the National Assistance Act 1948. A key piece of legislation was the NHS and Community Care Act 1990 which placed a duty on local authorities to assess individuals who might be in need of community care services and then, depending on the outcome of the assessment, meet identified social care needs.
In general terms adult social care has included the commissioning and provision of care in the home, meals, equipment and adaptations, day services, residential and nursing home care.
The statutory requirements remain but in recent years there has been a transformation in the social care sector, in particular a greater focus on “personalisation”. This involves putting the individual at the centre of the process of identifying their needs, and helping them to make choices about how they are supported. It emphasises greater choice and control for people over the services and support that are provided.

Kent, along with partner organisations has taken significant steps to transform and redesign systems and models of care and support in the county. This has been achieved whilst sustaining a strong performance culture and at a time of demographic change and rising expectations. Services are more personalised with people having greater choice and control through personal budgets, direct payments and self□directed support. The enablement service, alongside the telecare and telehealth developments and supported living schemes, has allowed people to remain independent whereas in the past they may have become dependent on long term care services.

Kent has also worked over a number of years to develop a flourishing private and voluntary sector, again where possible providing people with a level of choice and flexibility over the services they receive.
Although much has been achieved there is still much to do. It is in this context that the OPPD division has identified the following key priority areas for 2013/14 under the following headings:-

- Prevention
- Productivity
- Partnership
- Procurement
- People
- Financial and Policy Challenges

Each of the priorities is important in its own right but particular mention should be made of Partnership as this involves health and social care integration and represents a major programme of change. The Health and Social Care Act 2012 would influence much of how the division works with the emerging NHS organisations; in particular, the Clinical Commissioning Groups (CCGs), Health Wellbeing Boards and public health. Formal implementation of the major changes commence April 2013 and are explained in further detail within this plan.

Prevention

Where people develop care and support needs, consideration should be given to how best to maintain and restore independence. This can prevent people from becoming dependent on long term care arrangements, such as residential and nursing home care, and can reduce the number of hospital admissions. A priority for OPPD is the development of a methodology to promote the use of 'self-care' for people with long term conditions who will benefit from early intervention and guidance on understanding how to manage their condition in the longer term.

For many people carers are the "first line" of prevention. The support of carers can often stop problems from escalating to the point where more intensive packages of support become necessary. KCC is in the process of implementing a Carers Strategy which will ensure that Carers are easily able to access services and are automatically offered assessment and support at the point of contact.

Kent has been selected as a 3Million Lives Pathfinder pilot which will enable a higher number of people in the County to have access to teletechnology - a key component of prevention which enables people to live independent lives. Kent has been at the forefront of developing Advance Assistive Technology and both telecare and telehealth have been mainstreamed.

A third component of prevention is Enablement. This is a short term intervention to assist people with recuperation. Service users are encouraged and shown ways to regain daily living skills. Evidence indicates that approximately 65% of people receiving enablement services require no immediate ongoing Social Services input at the end of the intervention.

OPPD works closely with the voluntary sector and other providers in the delivery of preventative services to build community capacity and develop more inclusive access and participation.

People need to have access to good information and advice to ensure they are able to access the right services at the right time and can use this information and advice as part of a structured way of managing their condition – self care. OPPD are developing channel shift options for the provision of Information, Advice and Guidance (IAG) so that information is easily accessible to all people in a wider variety of ways.

Productivity

A priority for 2013/2014 is to continue to develop improved performance and increased productivity within the Division. This will involve the review of roles and responsibilities of all staff and link to the development of the Organisational Development

workforce plan. The Division needs to ensure that the workforce are fully skilled and able to deliver and meet the needs of the people of Kent. We will review services to identify more efficient processes, for example a review of the Assessment and Enablement and Co-ordination functions is proposed for 2013/14.

The introduction of single points of access across the County will be complemented by the development of a single assessment and Trusted assessor assessments, integrated anticipatory care planning for End of Life Services. This will be achieved by joint working initiatives with our partner agencies and will reduce duplication and create more effective service delivery.

A continuing priority for 2013/14 is to manage performance and maintain and improve service standards. Robust performance and information management is critical to ensuring the OPPD division is able to meet key objectives, is performing effectively, offers value for money and recognises and manages any risks to delivery. In addition to monitoring key performance indicators, OPPD will continue to promote quality, dignity and best practice - learning when things go well in addition to learning from complaints and service reviews.

Performance management is relevant across the board whether it be assessment services or commissioned or provided services.

Partnership

There will be a continued focus on more integrated health, housing and social care support arrangements. In Kent integration of services is being taken forward at a number of levels including:

- Developing locality prevention strategies to reduce admissions to hospital and limit future provision of long term support and care.
- Managing the hospital and long term care system as a "whole system" so interventions can be made more systematically and avoid inappropriate hospital admissions.
- Developing adult community health and social care teams in partnership with General Practitioners, Kent Community Health NHS Trust and Kent & Medway Health and Social Care Partnership Trust to build a platform for providing increased community support to people with long term conditions.
- The introduction of integrated single points of access to co-ordinate referrals to health and social care
- Exploring the development of housing opportunities including extra care housing.
- Establishing joint locality based commissioning with the CCGs of some services with a particular focus on the Urgent Care and
- Long Term Care agenda
- Develop services for people with Dementia in partnership with CCGs and in line with the Prime Minister's challenge bids in relation to increased diagnosis rates, quality of care in hospital, developing dementia friendly communities and intergenerational work.

In addition to greater integration with health, the OPPD division works closely with the housing authorities and this forms part of the transformation agenda.

The KCC strategy "Excellent Homes for All" sets out to improve the county's housing and care infrastructure by increasing the stock capacity and improving the options available for vulnerable people. It is expected to deliver 220 units of specialist housing for vulnerable people – particularly extra care housing for older people.

Procurement

OPPD will assist Strategic Commissioning colleagues to manage the market to ensure value for money and to provide choice including for people on direct payments. OPPD is assisting with the pilot to enable people eligible for NHS Continuing Health Care to have the option of a direct payment to purchase health care. Integrated health and social care budgets have been piloted in the Dover area and it is anticipated that the roll out of this service will continue in 2013/14.

In collaboration with strategic commissioning, OPPD has a role in helping the development of a flourishing and diverse social care market where people on personal budgets or direct payments can commission their own support to enable them to achieve their ambitions and aspirations

It is planned to increase the use of the Kent Card by people who opt for direct payments and also to use the Kent Card for people on Personal Health Budgets. KCC has played a major role in supporting personal health budgets, by sharing lessons, processes and tools such as the Kent Card. The Kent Card contract is due to be reviewed and retendered during 2013/14. It is anticipated that once the new contract is in place, Kent Card will become the default option for people who have a Direct payment.

OPPD will work with Strategic Commissioning in procuring new Assistive technologies as a Department of Health Pathfinder for 3 Million Lives. It is planned that providers of technologies and commissioners will develop partnership strategies for procuring managed services.

People

Personalisation is a key element of the social care transformation agenda. Personal budgets, generally in the form of direct payments are a powerful way of giving individuals the control of their personal care and independence. Personalisation ensures that people have real autonomy and choice.

Providing choice and involving service users and carers in decision making is a key component of personalised social care services. In Kent self –directed support initiatives have helped develop personalisation but more is to be done to encourage the take up of direct payments as an alternative to direct provision.

We will ensure that we respond appropriately to safeguarding issues when they occur. In 2012/13 the Central Referral Unit was

created which works alongside a single point of contact for safeguarding referrals. We will continue to work with the private care sector to improve the level of dignity and quality in care. Key partners will be the Care Quality Commission and Local Local Government Ombudsman.

Financial and Policy Challenges

To monitor progress of the Care and Support Bill to prepare for any changes and assess the impact it will have on services in Kent (e.g. changes to legislation, charging).

Continue to ensure value for money and check that "every penny counts".

Prepare for legislation that is likely to reform Special Educational Needs (SEN) and disability services

Progress work on the integration of health and social care services.

Implement the Transformation Programme.

Older People /Physical Disabilities Services

The OPPD division has 6 localities ensuring services are delivered at a local level and reflect the needs of the communities that they serve.

Currently the service is comprised of:-
Assessment and Enablement Services
Co-ordination Services
Modernised in-house services (providing residential and day care)
Enablement Services
Community Equipment Services
Sensory Services (This includes in-house services such as the Deaf Services teams and contracted services such as Kent Association for the Blind and Hi Kent)
Operational Support Unit
Autism/Aspergers Assessment Service

Workforce planning proposals within the Division are likely to result in a reconfiguration of the teams as the review of roles and responsibilities is carried out. Integration proposals will require alignment with Clinical Commissioning Group boundaries as part of the health and social care integration agenda.

SECTION B: CONTRIBUTION TO MTP OBJECTIVES

As a Business Unit within KCC and as part of the Families and Social Care Directorate, the OPPD Division is committed to the Bold Steps agenda and the concept of One Council. This includes the following three aims:-

- To help the Kent economy to grow
- To put the citizen in control
- To tackle disadvantage.

The Bold Steps for Kent Delivery Framework 2012 identified 16 key priorities. For OPPD, the key aims and relevant priorities from this list are detailed below:-

1. Improve how we procure and commission services
2. Support the transformation of health and social care in Kent
3. Build a strong relationship with key business sectors across Kent
4. Support new housing growth that is affordable, sustainable and with the appropriate infrastructure
5. Improve access to public services and move towards a single initial assessment process
6. Empower social service users through increased use of personal budgets
7. Ensure the most robust and effective public protection arrangements
8. Improve services for the most vulnerable people in Kent
9. Support families with complex needs and increase the use of community budgets

These priorities are consistent with OPPD's work on developing a flourishing independent care sector; promoting self-directed support; and empowering vulnerable people to live independent and fulfilling lives.

Adult social care is continuing its programme of modernisation for all clients groups. This is in the context of budgetary pressures, growing demand for services and recognising that services will need to be delivered differently if the same level of service is to be provided whilst making every penny count.

Summary of Key Priorities for OPPD

Our focus for 2013/2014 will be to:-

1. Develop the option for people to self-care by designing a methodology to identify people with long term conditions who would benefit from the provision of structured Information, advice and guidance to enable them to self manage in the future.
2. Ensure that organisational development is linked to the key priorities and workforce development.
3. Review current safeguarding management arrangements in light of recent CQC and LGO findings to ensure that we are able to develop an in-depth knowledge of the issues within the Care Sector and develop systems that monitor quality and dignity effectively and are fit for purpose. OPPD will look at the best way they can enhance the Safeguarding function to support quality care provision within the private and independent sector.
4. Work closely with Strategic Commissioning around the development of the Accommodation Strategy and link with colleagues in District and Borough Councils and private and voluntary providers to implement the strategy for the benefit of the people in Kent.
5. Expand the development of service specific areas – Dementia; Autistic Spectrum conditions and End of life care ensuring that the previous consultations and co-production feedback from service users and the public is taken on board.
6. Develop adult placement service for Older People and people with Dementia using funding from the Dementia challenge fund. The scheme will be known as Shared Lives and is part of a 2 year research project with Kent University along with Leeds and Oxford Local Authorities.
7. Develop services with the CCG and other partners which focus on people with Long Term Conditions and the Urgent Care agenda.
8. Roll out Assistive technologies at pace and scale jointly with CCGs and the DH as a Pathfinder for 3 Million Lives.

Transformation Plan

A priority for 2013/14 is to maintain the delivery of quality services at a time of austerity and financial constraint. This will be achieved through a programme of transformation which will include an appraisal of options and where appropriate changes to services and new ways of working. Through the delivery of the Transformation Programme Families and Social Care will ensure that people are at the heart of all adult social care activities, receive integrated services that are easy to access, of good quality and that maximise their ability to live independently and safely in their community. This requires a high level review of how social care is currently delivered whilst recognising the financial constraints of the current climate. Service redesign will be achieved by understanding the relationship and interdependencies between our key activities, appraising the options and implementing the changes.

Workforce Development

OPPD have implemented an Organisation Development Group (ODG) which will focus on the KCC Organisation Development and People Plan, and FSC and OPPD Organisation Development Plans, to ensure that OPPD staff develop their knowledge, skills and behaviours to meet future challenges and opportunities.

The Group will:

- Produce a Divisional Organisation Development Plan
- Consider the implications for OPPD of KCC and FSC Organisation Development Plans
- Identify new and emerging learning and development needs for the OPPD Division and update Organisation Development plans accordingly
- Consider the implications for OPPD staff of national workforce strategies and requirements
- Take decisive action on behalf of OPPD DivMT to ensure agreed organisation development actions are implemented and monitored
- Produce proposals and recommendations to present to the FSC Organisation Development Group and OPPD DivMT
- Consider appropriate subjects for the Big Exchange managers events
- Consider appropriate subjects for the Administrative Staff Forums

The Kent Manager Certified award has been rolled out to OPPD staff for completion and will ensure that all Managers within the Division demonstrate consistent standards and skills.

The ODG will also ensure that KCC Equality objectives are incorporated within the Divisional Organisation Development Plan.

Key Decisions

A number of activities would be progressed for Members consideration under the Key Decision procedures:

A. Review and update Section 75 for Integrated Care Centres. Decision planned for September 2013

SECTION C: PRIORITIES, ACTIONS, PROGRAMMES, PROJECTS, MILESTONES, KEY OR SIGNIFICANT DECISIONS				
Management Teams are required to regularly review progress against the actions and milestones set out in the tables below. Monthly progress may be appropriate for individual services to review their business plan progress, and quarterly may be appropriate at the Divisional level. Formal reporting of progress by Division to Cabinet Committees is required twice a year, at the mid-year point and after the year-end. The Corporate Director is authorised to negotiate, settle the terms of, and enter the following agreements/projects:				
PRIORITY 1: Prevention		**DESCRIPTION OF PRIORITY:** Maintaining and promoting independence for service users by improving access to services, equipment and information, advice and guidance		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Improve public information to give people more information about independence, choice and control**.	Anne Tidmarsh	April 2013	March 2014
1.1	Working closely with Customer and Communities to identify the options for Channel shift to ensure best practice in the provision of IAG for customers. Develop options for provision as part of the transformation agenda.	Melanie Hayes	December 2012	March 2014
2	**Promote enablement and target interventions so that fewer people become dependent on long term care and support services.** **Build community capacity and develop more inclusive access and participation**	Anne Tidmarsh	April 2013	March 2014
2.1	Increase use of enablement to prevent the need for long term care (domiciliary and residential) and provide out of hours access to enablement and intermediate care.	Heads of Service	April 2013	March 2014
2.2	Increase in-house utilisation rates for enablement services (community and bed based)	Jim Gillespie/ Caroline Hillen	April 2013	March 2014
2.3	To explore and eliminate any duplication between KCC's enablement service, Intermediate Care Service	Anne Tidmarsh	April 2013	March 2014

	(KCC and Health joint funded) and Rapid Response service (provided by Health)			
2.4	To explore an alternative delivery model for enablement services which is able to reduce the cost of the service, whilst improving outcomes for users.	Juliet Doswell/ Jo Empson	April 2012	August 2013
2.5	Develop the use of technology to complement the provision of an enablement service.	James Lampert	April 2013	March 2014
3	**Service specific Developments:- Dementia, Autistic Spectrum Condition and End of Life Care**	Anne Tidmarsh		
3.1	Develop the adult placement service – Shared Lives utilising funding secured from Dementia Challenge	Jane Barnes/Kelly Ann Field	November 2012	March 2015
3.2	Implementation of the Integrated Dementia commissioning plan and the Dementia Select Committee recommendations	Emma Hanson/Heads of Service	April 2013	March 2014
3.3	Implementation of the Prime Minister's Challenge bids in relation to Dementia friendly communities and increasing inter-generational community cross over and involvement	Emma Hanson/Heads of Service	April 2013	March 2014
3.4	Full implementation of the Autistic Spectrum Condition (ASC) team and development of the integrated model working in partnership with KPMT	Beryl Palmer/ Mike Powe	April 2013	March 2014
3.5	The team will complete all initial assessments and diagnosis of people with Autistic Spectrum Condition	Beryl Palmer	April 2013	March 2014
3.6	Expansion of the provision of voluntary sector based support services for people with ASC	Beryl Palmer/ Guy Offord	April 2013	March 2014
3.7	Development of an integrated framework for End of Life care in Kent	Anne Tidmarsh/ James Lampert	April 2013	March 2014
3.8	Development of the adult social care offer for End of Life care.	Heads of Service	April 2013	March 2014
4	**Improve access to services for carers**	Anne Tidmarsh	April 2013	March 2014
4.1	Work with Strategic Commissioning to ensure that the uptake of carers assessments is increased and that carers are informed of services available to them	Heads of Service/Team Managers	April 2013	March 2014
4.2	All known Carers signposted to contracted providers for Carers assessment and support	Heads of Service/Team Managers	April 2013	March 2014
4.3	Carers assessments offered to all eligible carers	Heads of Service/Team Managers	April 2013	March 2014

4.4	Carers treated as an expert partner in care by all OPPD care management teams	Heads of Service/Team Managers	April 2013	March 2014
5	**Further promote the use of assistive technology and other equipment to enable people to live independently**	James Lampert/Heads of Service	April 2013	March 2014
5.1	Refresh the Telecare strategy and commissioning plan to reflect Kent as a Pathfinder for the 3Million Lives programme doubling the usage and using different technologies and delivery models	James Lampert/ Anne Tidmarsh	April 2013	March 2014
5.2	Encourage and increase take up of tele-technology equipment to support people in community settings	Mary Silverton / Heads of Service	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Transformation Board approval of options paper to determine direction for delivery of IAG services to be used as action plan for service design and implementation	December 2012/January 2013
B	Review of current enablement service delivery and providers	January 2013/April 2013
C	Work with Strategic Commissioning on the tendering process for future enablement services	April 2013
D	38% of all Carers receive a needs assessment or review resulting in specific carers service or information and advice	March 2014
E	Review of the Adult placement service project to determine roll out across the County	March 2014
F	Telecare strategy refresh	April 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 2: Productivity		**DESCRIPTION OF PRIORITY:** Transformation of service provision incorporating service review and redesign to increase efficiency, remove duplication and achieve value for money		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Continue to develop and implement the Transformation Programme to identify new ways of working.**	Anne Tidmarsh	April 2013	March 2014
1.1	Ensure enablement and/or enabling support is at the heart of our service offering and develop Locality referral management services for increased and faster take up of enablement services	Heads of Service	April 2013	June 2013
1.2	Ensure alternative models of care (specifically technological solutions) are considered as viable options	Heads of Service	April 2013	March 2014
1.3	Optimise usage of enablement and develop the delivery of accurate and useful performance data to evidence on-going improvement (using financial and non-financial measures)	Heads of Service/ Steph Abbott / Richard Benjamin	April 2013	March 2014
1.4	Optimise use of qualified professional time for service user contact; optimise use of support services for business processes	Heads of Service	April 2013	Sept 2013
2	**Review services to identify more efficient processes e.g. assessment and enablement and co-ordination**	Anne Tidmarsh	April 2013	July 2013
3.	**Identify opportunities for joint work with partner agencies to reduce any duplication**	Anne Tidmarsh	April 2013	March 2014
3.1	Expansion of assessment and review clinics and fast track services, working with partners such as Gateways, District councils, independent and voluntary sector providers	Heads of Service	April 2013	March 2014
3.2	Develop one Assessment and single Anticipatory Care Plan with health providers	HOS, Janice Grant	April 2013	Sept 2013

KEY MILESTONES		DATE (month/year)
A	The outcome of the tendering exercise for the KCC transformation Efficiency Partner is required to determine the direction of travel for the transformation agenda within OPPD	March 2013
B	Ensure enablement and telecare targets are embedded within locality and staff action plans	May 2013
C	Assessment and Anticipatory Care plan developed and implemented	September 2013
D	Have new business processes in place for both qualified and support staff	July 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Potential impact on staffing structures	No

PRIORITY 3: Partnership		**DESCRIPTION OF PRIORITY:** Building partnerships and improved relationships with a wide range of private, independent and health partners to ensure services are outcome focused and achieved		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Work with the new Clinical Commissioning Groups (CCGs) to ensure coherent processes and systems across health and social care and to identify opportunities for integrated commissioning and working**	Anne Tidmarsh	April 2013	March 2014
1.1	Establish joint locality commissioning processes with the CCGs**.**	James Lampert / Heads of Service	April 2013	March 2014
1.2	Developing the Long Term Conditions plan for Kent as set out in the Health and Wellbeing Boards priorities and in partnership with the NHS	James Lampert / Anne Tidmarsh	April 2013	Oct 2014
1.3	Implementation of Risk stratification for integrated teams, using anticipatory care planning and admission avoidance crisis services	Jo Frazer / Janice Grant/ HOS / Paula parker	April 2013	Oct 2014

1.4	Joint health and social care integrated teams to be in place in all localities, co-located where possible.	Heads of Service	April 2013	Oct 2013
1.5	Single points of access/Single referral services to be in place in all localities and operating on an Enhanced Hours basis (8-8 , 7 days a week)	Fiona Dempster / Heads of Service	April 2013	March 2014
1.6	Self care developed as a part of the offer from the Integrated teams for people who have a Long Term Condition	Heads of Service/Jo Frazer	April 2013	March 2014
1.7	Develop the use of supporting tools for people with Long Term Conditions:- Integrated personal budgets to be doubled in South Kent coast region Patient knows best to be utilised for people with LTC in Swale and Pro-active Care in South Kent coast Discharge services in Maidstone and Tunbridge Wells hospitals will be transformed with the development of new discharge model – 'Own bed, best bed', in partnership with East Kent Hospital Foundation Trust	Heads of Service/Paula Parker	April 2013	March 2014
2	**Work with housing providers to increase housing choices for older and disabled people.**	Anne Tidmarsh	April 2013	March 2014
2.1	Implementation of the Accommodation Strategy	Anne Tidmarsh/Christy Holden	April 2013	March 2014
2.2	Locality based health, housing and social care groups to be established	Heads of Service	April 2013	March 2014
2.3	Implementation of the Excellent Homes for All scheme	Sarah Naylor	April 2013	March 2014
2.4	Development of Farrow Court in Ashford working in partnership with Ashford Borough Council to become a Dementia and vulnerable adults friendly community	Christy Holden / Mary Silverton	April 2013	March 2014
2.5	Development of Extra Care Housing in Swale	Mike Powe/ Christy Holden	April 2013	March 2014
2.6	Promote the growth of PD friendly, accessible housing by ensuring the design of future housing development is compliant, through the use of Section 106 funding	Christy Holden /Heads of Service	April 2013	March 2014
KEY MILESTONES				DATE (month/year)
A	'Own bed, best bed model implemented'			September 2013

B	Accommodation strategy developed	July 2013
C	Integrated health and social care teams established in all localities	October 2013
D	Utilise DH funding on going further, faster sites in the County to increase Personal Health Budget take up	April 2013
E	Hold workshops and training for staff in the localities to raise awareness of Personal Health Budgets	April 2013
F	Launch Self-care service within the localities working with integrated teams	October 2014
G	Launch Patient Knows Best and Pro-active care pilots in Swale and South Kent	April 2013
H	Development plan for Farrow Court written and agreed with Ashford BC	June 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 4: Procurement		**DESCRIPTION OF PRIORITY:** Managing the market and commissioning intelligently to gain best value, flexibility and choice		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Manage the market to ensure value for money and to provide choice including for people on direct payments**	Anne Tidmarsh	April 2013	March 2014
1.1	Work closely with Strategic Commissioning to ensure that services provided reflect the requirements and needs of OPPD service users and are flexible in terms of choice	Anne Tidmarsh/Heads of Service	April 2013	March 2014
1.2	Continue to develop the provision of Provider Managed Services within OPPD and increase uptake Including Assistive Technologies	Heads of Service	April 2013	March 2014
2.	**Kent Card:-**			

2.1	Review of the contract for Kent Card to be carried out and a re-tender to be completed. Once completed, the new Kent Card will become the default option for delivering Direct Payments	Gina Walton	February 2013	March 2014
3.	**Personal Health Budgets:-**			
3.1	Develop an integrated personal budget programme with South Kent Coast CCG and KCC to test integrated budgets to inform wider roll out across the country.	Gina Walton	April 2013	March 2014
3.2	Work with the NHS to deliver personal health budgets for Continuing Health Care – developing a seamless service for clients who transition from social care funding into health funding	Gina Walton/ Mary Silverton	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Commence tendering process for Kent Card	Jan/Feb 2013
B	Implement new Kent Card within FSC	May 2013
C	Integrated personal budget programme developed and implemented	March 2014
D	Working relationships and communication links established with Strategic Commissioning	March/April 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	New Kent Card provider	No

PRIORITY 5: People		**DESCRIPTION OF PRIORITY:** Promote personalisation for users to ensure increased choice and control with services offered being accessible and driven by customer demand		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Further promote personalisation giving people genuine choice and control over their lives**.	Anne Tidmarsh	April 2013	March 2014

	Development of Kent Card for use by people who opt for Direct Payments and for use in Personal Health Budgets for people who are in receipt of Continuing Health Care Funding	Gina Walton	April 2013	March 2014
2	**Ensure services are customer-centric with clear information, access, complaints processes and quality assurance**	Heads of Service/Team Managers	April 2013	March 2014
2.1	Centralise customer care teams within FSC to create one team dealing with all FSC complaints – children's and adults	Anne Tidmarsh	October 2012	April 2013
2.2	Link with KCC customer feedback project as part of the one council approach to customer complaints and feedback – streamline complaints process making it easier for customers to contact the Council	Anne Tidmarsh	October 2012	April 2013
2.3	Complete an Equality Impact Assessment in relation to the changes of the customer feedback process and the impact on FSC service users.	Pascale Blackburn-Clark/Tanya Parker	January 2013	February 2013
2.4	Continued use of Co-Production for the development of dementia and ASC services	Emma Barrett / Emma Hanson/ Beryl Palmer	April 2013	March 2014
3	**Continue to review safeguarding arrangements to ensure the protection of vulnerable people**	Anne Tidmarsh	April 2013	March 2014
3.1	Work with partners, including the NHS, police and criminal justice system to safeguard vulnerable people and, if they are victims of crime, ensure they have access to justice and support.	Heads of Service/Team Managers	April 2013	March 2014
3.2	Use and develop the Safeguarding Vulnerable Adults Competency Framework to evidence the competence of community teams to deal with safeguarding issues	Nick Sherlock/Carol McKeough	April 2013	March 2014
	Reduce the number of Safeguarding Cases open beyond 6 months	Heads of Service/Team Managers	April 2013	March 2014
	Work with the care sector to improve dignity and quality in care and develop a methodology to identify early systemic failures in service delivery	Nick Sherlock/Christy Holden/Heads of Service	April 2013	March 2014
4.	**Workforce Development**	Anne Tidmarsh	April 2013	March 2014

4.1	Developing modular based development programmes for case management staff	Jane Barnes/Mags Harrison	April 2013	March 2014
4.2	Developing our approach to Assessed and Supported Year of Employment	Jane Barnes/Mags Harrison	April 2013	March 2014
4.3	Re-commissioning the National Skills Academy for Social Care front line leaders programme	Jane Barnes/Mags Harrison	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Customer care centralised team structure agreed by DMT	April 2013
B	Centralised customer care team structure implemented	June 2013
C	Customer complaints process for FSC developed to align with KCC one council feedback approach	September 2013
D	Performance monitoring of safeguarding cases included within locality performance frameworks	April 2013
E	National Skills Academy for frontline leaders programme implemented for FSC staff	January 2014
F	Develop methodology for early identification of care and quality issues in the care sector	August 2013
G	Workforce development plan completed and implemented	March 2014

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 6: Financial and Policy Challenges		**DESCRIPTION OF PRIORITY:** Future planning of service and budgets within the division to meet legislative requirements on time with the minimum of disruption to end users		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**To monitor progress of the Care and Support Bill to prepare for any changes and assess the impact it will have on services in Kent (e.g. changes to legislation, charging)**	Anne Tidmarsh/ Janice Grant	April 2013	March 2014
2	**Prepare for legislation that is likely to reform SEN and disability services**	Anne Tidmarsh/Anthony Mort	April 2013	March 2014
3.	**Implement the Transformation programme**	Anne Tidmarsh/Heads of Service	April 2013	March 2014
3.1	Ensure that service users access the right service at the right time at the right cost	Heads of Service/ Sharon Buckingham	April 2013	March 2014
3.2	Work with the Transformation team and the Efficiency partner to implement changes identified within the diagnostic evaluation	Anne Tidmarsh/Heads of Service	February 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Care and Support Bill legislation to be translated into operational and policy protocols	March 2014
B	Access to resource protocols in place for use in Localities	April 2013
C	SEN legislation translated into operational and policy protocols	March 2014
D	Optimisation work implemented	March 2014

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

SECTION D: FINANCIAL AND HUMAN RESOURCES

Financial information will not be available until after the 2013-14 budget has been agreed by County Council (projected March 2013-14

For the Financial Resources section **Finance** will provide the required information and detail that sets out the main components of your budget by completing the table below.

FINANCIAL RESOURCES								
Divisional Unit	**Responsible Manager**	**Staffing**	**Non Staffing**	**Gross Expenditure**	**Service Income**	**Net Expenditure**	**Govt. Grants**	**Net Cost**
		£	**£**	**£**	**£**	**£**	**£**	**£**

HUMAN RESOURCES		
FTE establishment at 31 March 2013	**Estimate of FTE establishment at 31 March 2014**	**Reasons for any variance**
1230.72		

Section E: Risks and Business Continuity	
Risks	
RISKS	MITIGATION
Transformation agenda and the need to introduce significant changes to ways of working	Transformation programme in place, blueprint produced, understand phase completed, exploring options including increasing prevention, access to enablement and ensuring value for money.
Further develop integration of health and social care services – at a time of significant organisational change	Working with colleagues in health to develop integrated ways of working through for example single points of access. Developing links with the new Clinical Commissioning Groups.
Increasing demand for social care services.	Building community capacity, supporting carers, improved advice and guidance to give people more independence. Use of risk stratification to identify future demand and target support interventions
Safeguarding vulnerable people	Kent Adult Safeguarding Board in place with key agencies. Peer reviews and audits conducted.
Need to Manage the market to ensure value for money	Close working with Strategic Commissioning and developing the Access to Resources function to ensure best value obtained from providers and new relationship with providers.
Need to ensure most efficient use of resources	Reviewing arrangements to ensure that services are organised in the most effective/efficient way e.g. review A & E and co-ordination arrangements
Need to sustain performance and quality	Regular performance monitoring, learning from customer feedback, and developing quality assurance function
Need to respond to developing areas of need e.g autism/dementia services .	Introducing the autism/aspergers service with health colleagues. Linking with strategic commissioning to commission dementia services

BUSINESS CONTINUITY

The Division has up-to-date Business Continuity Plans in order to provide essential services when faced with a business disruption. Each department has undertaken a Business Impact Analysis and produced a Business Continuity Plan. In addition, business continuity planning forms part of the contracting arrangements with our private and voluntary sector providers. Our plans provide assurance that effective risk and business continuity management is being undertaken for each service, and that there is a clear synergy between the business plan, service risk register, and business continuity plan.

Business Impact Analysis is reviewed at least every 12 months, or when substantive changes in processes and priorities are identified. The availability of up-to-date plans will ensure that the Directorate can continue to operate and provide essential services, at least, to a pre-determined minimum level, in the event of a major business disruption.

The table below headlines the Division's most critical processes and the minimum level of service at which the function will be delivered following a significant business disruption. Further details regarding critical functions and their supporting resources are detailed in the Directorate's Business Impact Analysis.

CRITICAL FUNCTIONS	TIMESCALE	MINIMUM SERVICE LEVEL
Local Access Response	4 Hours	Maintain critical access for the public and multi-agency partners to adult social care services including the commissioning and provision of care in the home, meals, equipment and adaptations, day services, residential and nursing home care.
Client and Business Information Management Processes	4 Hours	Maintain client records and critical business information (client records, financial, contractual, systems, other information assets) and all aspects of record keeping, including hardcopy and electronic data formats (Swift), in line with Information Governance procedures.
Referral Processes	4 Hours	Manage referrals requesting new assessment of needs. Risk assess and prioritising and allocating in order of urgency.
Enablement at Home Service	4 Hours	Manage referrals from Assessment and Enablement (incl hospitals) and Co ordination Services to provide enablement services to service users in their own home.
Safeguarding Processes	4 Hours	Manage safeguarding alerts regarding new or existing Service Users. Undertake Adult Protection assessment, strategy discussion and decision on further action required including investigation and intervention, case conference requirements and multi agency participation.

Case Management and Assessment Processes	4 Hours	Manage priority information regarding new or existing Service Users' changes of circumstances to assess/ re-assess, risk assess and prioritise in urgency of need, develop new Support Plan including brokerage (if appropriate) and to set up actual budget and revise/ cancel/ postpone services. Procure services or equipment as part of support plan.
Hospital Discharge Assessment Processes	4 Hours	Manage referrals, prioritising and allocating in order of urgency. Carry out assessment, arrange services and facilitate timely and safe hospital discharges for service users, to prevent delays and consequent bed shortages. Co-ordinate referrals to Co-ordination teams or Enablement at Home to provide service to users.
Careline Service	4 Hours	Manage Careline Service to provide critical support to community based staff, response to Telecare systems calls and referrals from Contact Kent.
Deaf and Deafblind Interpreter Service	4 Hours	Manage essential access and provision of countywide deaf and deafblind interpreter service.
Residential and Day Care Operations Processes	4 Hours	Manage all critical Residential and Day Care operation s to provide and maintain a safe/secure environment conducive to meeting the needs of staff and service users to meet their accommodation needs.

SECTION F: PERFORMANCE AND ACTIVITY INDICATORS - Information to be added in January 2013

Table for PERFORMANCE indicators measurable on a quarterly basis by financial year

PERFORMANCE INDICATORS – QUARTERLY BY FINANCIAL YEAR	Floor Performance Standard	2012/2013 Outturn	Comparative Benchmark	Target			
				Q1	Q2	Q3	Q4

Table for PERFORMANCE indicators measurable on a termly basis by academic year

PERFORMANCE INDICATOR – TERMLY BY ACADEMIC YEAR	Floor Performance Standard	Aut 12 Outturn	Comparative Benchmark	Target – terms end dates			
				Spr 13	Sum 13	Aut 13	Spr 14

Table for PERFORMANCE indicators measurable annually by financial year

PERFORMANCE INDICATOR - ANNUALLY BY FINANCIAL YEAR	Floor Performance Standard	2012/13 Outturn	Comparative Benchmark	Target 2013/14	Target 2014/15

Table for PERFORMANCE indicators measurable annually by academic year

PERFORMANCE INDICATOR - ANNUALLY BY ACADEMIC YEAR	Floor Performance Standard	2012 Outturn	Comparative Benchmark	Target 2013	Target 2014

Table for ACTIVITY indicators measurable on a quarterly basis by financial year

ACTIVITY INDICATOR	2012/13 Outturn	Comparati ve	Expected range for activity

			Threshold	Q1	Q2	Q3	Q4
			Upper				
			Lower				
			Upper				
			Lower				

SECTION G: ACTIVITY REQUIRING SUPPORT FROM OTHER DIVISIONS/SERVICES (For example Property, ICT, Business Strategy, Human Resources, Finance & Procurement, Planning & Environment, Public Health, Service Improvement, Commercial Services, Governance & Law, Customer Relationships, Communications & Community Engagement or other Divisions/Services)		
ACTIVITY DETAILS	EXPECTED IMPACT	EXPECTED DATE
Kent Card re-tender	Strategic Commissioning	Feb 2013
Accommodation Strategy	Strategic Commissioning	April 2013
Review of A&E and Co-ordination	Human Resources	TBC
Increased uptake of tele-technology	Operational Support	April 2013
Channel shift, IAG options development	Customer and Communities	April 2013
Customer Care Review	Customer and Communities	January 2013
Implementation of the Transformation agenda	Transformation team, Operational Support	March 2013

Divisional Business Plan 2013-14

Families & Social Care
Learning Disability/Mental Health
Final Draft v 6 (16/12/2012)

Executive Summary:	
Cabinet Portfolio:	Graham Gibbens – Cabinet Member for Adult Social Care & Public Health
Responsible Corporate Director :	Andrew Ireland
Responsible Director:	Penny Southern
Head(s) of Service:	Mark Walker, Chris Beaney, Cheryl Fenton
Gross Expenditure:	£172.233m (2012/13)
FTE:	757.2 (Nov 2012)

SECTION A: ROLE/PURPOSE OF FUNCTION

The aim for Learning Disability and Mental Health services is to provide quality services in a personalised way so that individuals (and carers) can receive the support they need in a way that enhances their independence. At this time of austerity and financial constraint there will certainly be challenges, however through carefully considered transformation of services and by working in partnership with others, we are confident of sustaining professional and person centred services.

The strategic direction for the Learning Disability/Mental Health Division is set out in two key documents. For learning disability the

'Partnership Strategy for Learning Disability in Kent 2012-15' has been produced by stakeholder groups from Kent NHS and Kent

County Council including service users. The 'Partnership Strategy for Learning Disability in Kent 2012-2015 can be viewed at:
http://www.kent.gov.uk/adult_social_services/your_social_services/services_and_support/learning_disability/plans_for_kent.aspx

For mental health 'Live it Well' is the strategy for improving the mental health and wellbeing of people in Kent and Medway 2010-15.

The 'Live it Well' strategy can be viewed at:
http://www.kent.gov.uk/adult_social_services/your_social_services/services_and_support/mental_health/improving_mental_health.aspx

These strategies set out how we are going to achieve the overall objective which is to help **the people of Kent to live independent and fulfilled lives safely in their local communities.**

Our key aims are to support people with learning disabilities and mental health needs to:
• Feel and be safe, free from discrimination or harassment;

• Maintain personal dignity and self-respect;

• Choose and control how they live their lives;
• Feel part of their local community and make a positive contribution;
• Access advice, information and services easily;
• Improve their health and quality of life;
• Maximise their economic wellbeing.

We will achieve this through:
• Putting people and their needs first;
• Supporting carers;
• Ensuring the availability of high quality services;
• Valuing, developing and supporting the social care work force;
• Working in partnership with individuals, families and other organisations;
• Making the best use of our resources;
• Creating the conditions, with others, for equality of opportunity;
• Constantly striving to improve.

SECTION B: CONTRIBUTION TO MTP OBJECTIVES

A clear message running through Bold Steps for Kent[1] is that residents should have more influence on how services are provided locally; this is in line with one of the main measures of the Localism Act, 2011. The key themes for Learning Disability and Mental Health Services are:

- Empowering residents through greater personalisation;
- Further integration of health and social care;
- Provision of job opportunities;

- Development of greater choice in housing;
- Supporting voluntary and community groups to deliver services;
- Continuing to ensure that safeguarding procedures are robust and effective.

The framework for delivering Bold Steps sets out 16 priorities. The Learning Disability and Mental Health services focus particularly on three of these priorities:

- Priority 12: Empower social services users through increased use of personal budgets,
- Priority 14: Ensure the most robust and effective public protection arrangements, and
- Priority 15: Improve services for the most vulnerable people in Kent.

However the services also contribute to three other priorities outlined in Bold Steps for Kent:

- Priority 1: Improve how we procure and commission services,
- Priority 2: Support the transformation of health and social care in Kent, and
- Priority 11: Improve access to public services and move towards a single initial assessment process.

The MTFP has identified that Families & Social Care needs to achieve £18.8 million of savings in 2013-14. This annual plan sets out the priorities for Learning Disability and Mental Health services 2013-14, detailing how it will contribute to the above Bold Steps Priorities and to overall savings.

A priority for 2013/14 is to maintain the delivery of quality services at a time of austerity and financial constraint. This will be achieved through a programme of transformation which will include an appraisal of options and where appropriate changes to services and new ways of working. Through the delivery of the Transformation Programme Families and Social Care will ensure that people are at the heart of all adult social care activities, receive integrated services that are easy to access, of good quality and that maximise their ability to live independently and safely in their community.

The KCC Budget Consultation and ‘Bold Steps’ progress report to County Council reference five ‘P’ themes that are of strategic importance to the organisation: prevention, productivity, partnership, procurement and people for 2013/14. FSC have utilised this the five ‘P’ framework to consider headline priorities for learning disability and mental health services which are outlined within this business plan.

SECTION C: PRIORITIES, ACTIONS, PROGRAMMES, PROJECTS, MILESTONES, KEY OR SIGNIFICANT DECISIONS				
Management Teams are required to regularly review progress against the actions and milestones set out in the tables below. Monthly progress may be appropriate for individual services to review their business plan progress, and quarterly may be appropriate at the Divisional level. Formal reporting of progress by Division to Cabinet Committees is required twice a year, at the mid-year point and after the year-end. The Corporate Director is authorised to negotiate, settle the terms of, and enter the following agreements/projects:				
PRIORITY 1: Prevention		**DESCRIPTION OF PRIORITY: Promote enablement, the use of assistive technology and community based interventions so that fewer people become dependent on long term care and are supported to plan for the future**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Promote enablement and target interventions so that fewer people become dependent on long term care services.**			
1.1	Delivery of the Supporting Independence pilot for adults with learning disabilities in Dover/ Thanet and commence delivery in Dartford, Gravesham and Swanley.	Chris Beaney/Mark Walker	April 2013	March 2014
1.2	Delivery of the Mental Health Short Term Recovery Model	KMPT & KCC Partnership Agreement/ Stephanie Clarke/ Andy Oldgrow	April 2013	March 2014
2	**Build community capacity and develop more inclusive access and participation.**			
2.1	Improve early public access via primary care, gateways and other community based initiatives	Chris Beaney/Mark Walker/ KMPT & KCC Partnership Agreement	April 2013	March 2014

2.2	Review and restructure the LD in-house day care team. Tender for five community based day services.	Chris Beaney/Mark Walker/Paula Watson	April 2013	March 2014
3	**Improve access to services for carers.**			
3.1	All known Carers signposted to contracted providers for Carers Assessment and Support	Locality Team Managers/Service Managers	April 2013	March 2014
3.2	Offer Carer Assessments to all eligible Carers	Locality Team Managers/Service Managers	April 2013	March 2014
3.3	Treat Carers as expert partners in care by Learning disability integrated teams and Mental Health care management teams	Locality Team Managers/Service Managers	April 2013	March 2014
4	**Further promote the use of assistive technology and other equipment to enable people to live independently.**			
4.1	Increase the number of people in receipt of and effectively using assistive technology and other equipment	Locality Team Managers/Service Managers	April 2013	March 2014
4.2	Review and re-launch telecare programme for LD in supported accommodation to reduce staff support	Locality Team Managers/Service Managers	April 2013	March 2014
5	**Improve public information to give people more information about independence, choice and control**			
5.1	Increase staff and service users/Carers awareness and understanding of personal budgets and associated payment methods	Locality Team Managers/Service Managers	April 2013	March 2014
KEY MILESTONES				DATE (month/year)
A	Review Supporting Independence Pilot in Dover/Thanet			Jan 2014

B	Implement Support Independence Pilot in Dartford, Gravesham and Swanley	April 2013
C	Mental Health Short Term Recovery Model implemented	Sept 2013
	Social care provision established in Health of the Nation Outcome Scales Payment by Results clusters	
D	Change day service provision through the Good Day Programme.	March 2014
E	Social Enterprise Tender/Right to challenge – 5 community based services	June 2013
F	38% of all Carers receive a needs assessment or review resulting in specific carers service or information and advice	March 2014
G	Launch a learning disability Telecare project	March 2014

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Change to the supply, procurement and delivery of day services for adults with learning disabilities	Yes

PRIORITY 2: Productivity		DESCRIPTION OF PRIORITY: Review services and processes to support the delivery of lean efficient services with minimal duplication		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Continue to develop and implement the Transformation Programme to identify new ways of working.**			
1.1	Define an overarching care management strategy for adults with learning disabilities To realign LD teams to ensure an equitable service across the County	Penny Southern/Chris Beaney/Mark Walker/Cheryl Fenton	April 2013	December 2013
1.2	Implement the findings of the AMHPS review with regards to the MH SW workforce.	Cheryl Fenton/Stephanie Clarke/Andy Oldgrow	April 2013	March 2014
1.3	Enablement and/or enabling support is made centre of service offer in relation to assessment, support planning, personalisation and service delivery	Locality Team Managers	April 2013	March 2014
1.4	Ensure alternative models of care (specifically technological solutions) are considered as viable options	Locality Team Managers	April 2013	March 2014
1.5	Reduce the number of people being placed in residential care - target set at 1260	Chris Beaney/Mark Walker	April 2013	March 2014
1.6	Develop robust performance monitoring to evidence on-going improvement (using financial and non-financial measures)	Locality Team Managers/ Service Managers	April 2013	March 2014

2	**Review services to identify more efficient processes**			
2.1	Implement changes following the review of Personalisation Coordinators and the way FSC delivers personalisation	Sharon Buckingham	April 2013	October 2013
2.2	Review Purchasing Coordinators role and ways of working	Sharon Buckingham	April 2013	October 2013
2.3	Review Care Management Assistants role and working practices in Mental Health services	Cheryl Fenton	June 2013	December 2013
2.4	Review ILS service. Develop promised models of delivery to ensure a consistent and suitable service across the County.	Mark Walker	April 2013	March 2014
2.5	Review the Swift system to ensure data is of a good quality, purposeful and up to date	Penny Southern/ Adults Systems Group	April 2013	March 2014
3	**Identify opportunities for joint work with partner agencies to reduce any duplication.**			
3.1	Optimise opportunities for integration with other partners	Chris Beaney/Mark Walker/Cheryl Fenton	April 2013	March 2014
3.2	Review current transition arrangements in adult social care to ensure smooth transition and ensuring the right support is available to assist people to lead independent lives..	Chris Beaney/Mark Walker/Anthony Mort/ MH Partnership Agreement	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	All eligible people referred are assessed within 28 days	March 2014
B	Delivery of Personalisation Review/Commence Implementation	April 2013
C	Delivery of Purchasing Coordinators Review	June 2013

D	Delivery of a Care Management Strategy for Learning Disability	December 2013
ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Associated with service review recommendations	No

PRIORITY 3: Partnership		**DESCRIPTION OF PRIORITY: To work with key partners to improve outcomes for service users and promote personalisation**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Work with the new CCGs to ensure coherent processes and systems across health and social care and to identify opportunities for integrated commissioning and working**			
1.1	To work with CCGs to raise awareness of integrated Learning Disability teams and improve joint working practices	Chris Beaney/Mark Walker	April 2013	March 2014
1.2	Ensuring each GP practice has a named practitioner from the local Team for People with Learning Disability Team allocated to them.	Locality Team Managers	April 2013	June 2013
1.3	Increasing access for people with learning disabilities to prevention, screening and health promotion including annual health checks.	Locality Team Managers	April 2013	March 2014
1.4	To work with CCGs to build on and improve joint working practices for adults with Mental Health needs	Cheryl Fenton/ MH Joint Commissioner	April 2013	March 2014
2	**Work with housing providers to increase housing choices for disabled people.**			
2.1	Ensure as many eligible users as possible are in stable accommodation	Locality Team Managers	April 2013	March 2014
3	**Work with the Kent Learning Disability Partnership**			

	Board to improve delivery on key areas for people with a disability			
3.1	To deliver and report against the Learning Disability Partnership Strategy annual plan utilising agreed reporting mechanism	Penny Southern/ Kent LD Partnership Board	April 2013	March 2014
3.2	District Partnership Groups and Partnership workstreams, supported to deliver and report against their respective annual plans	Penny Southern/ Kent LD Partnership Board	April 2013	March 2014
3.3	Local representation of people with learning disabilities and family/carers clear throughout the Partnership Structure	Penny Southern/ Kent LD Partnership Board	April 2013	March 2014
4	**Work with KMPT to improve outcomes for service users and promote personalisation**		April 2013	March 2014
4.1	Improve the professional supervision and support for social care staff, including training and communication	Cheryl Fenton	April 2013	March 2014
4.2	Increase the number of Fair Access to Care assessments recorded by KMPT. To be monitored monthly at Divisional Management Team.	Cheryl Fenton	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	100% GP practices have named practitioner allocated to them from local Team.	March 2014
B	At least 65% of eligible people with learning disabilities are in stable accommodation	March 2014
C	Report to the Learning Disability Partnership on the delivery of the priorities outlined in the Kent Learning Disability Partnership Strategy	March 2014
D	Increase in the number of FACS assessments recorded by KMPT compared to March 2014	March 2014

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 4: Procurement		DESCRIPTION OF PRIORITY: To work alongside procurement and strategic commissioning to ensure that the market is able to provide services at the best price and quality to meet individual outcomes		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Develop the access to resources arrangements to purchase services at the best price and quality**			
1.1	Review and complete implementation of the Access to Resource team within the Operational Support Unit	Sharon Buckingham	April 2013	March 2014
1.2	Mechanisms and measures are in place that ensure all placements are value for money for the individual and the Council	Sharon Buckingham	April 2013	March 2014
1.3	Develop a clear understanding of the current market place to ensure effective purchasing strategies and promote choice including for people on direct payments	Sharon Buckingham	April 2013	March 2014
2	**Develop commissioning plans for specific service areas**			
2.1	Scope and understand the accommodation based respite provision for adults learning disability. Develop and implement strategic options for the new short breaks/Respite service	Paula Watson/Chris Beaney	April 2013	Jan 2014

2.2	Review transport arrangement for all Adult Social Care service users who receive KCC funded transport in order to access services.	Mark Walker/Chris Beaney	April 2013	March 2014
2.3	Implementation of new service models following formal consultation in: Thanet, Shepway & Tonbridge. Development of community hubs in Shepway, Thanet, Tonbridge, Tunbridge Wells, Dartford, Gravesham, Canterbury and Dover. Deliver the community Hydrotherapy Project	Paula Watson	April 2013	March 2014
2.4	Review Adult Protection Service and explore the potential appetite for micro provision for day care	Mark Walker	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Access to Resources Team fully established and functioning	May 2013
B	Commence formal consultation re accommodation based respite for adults with a learning disability	June 2013
C	Agree and implement recommendations re learning disability respite provision	October 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Potential changes to the supply and delivery of accommodation based respite	Yes
2	Potential changes to the procurement and delivery of transport provision	Yes

PRIORITY 5: People		DESCRIPTION OF PRIORITY: To ensure that service users are kept safe and enabled to achieve genuine choice and control. To ensure staff are supported to promote personalisation and deliver the core business.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Further promote personalisation giving people genuine choice and control over their lives**			
1.1	Ensure that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is	Mark Walker/Chris Beaney/Cheryl Fenton	April 2012	March 2014
1.2	deliver a continued high standard of core service to adults with learning disabilities and mental health problems meeting eligible needs following a timely assessment.	Locality Team Managers/ Service Managers	April 2013	March 2014
1.3	Implement the action plan to deliver personalisation in Mental Health	Penny Southern	April 2013	March 2014
1.4	Record and report Personal Budgets	Locality Team Managers/ Service Managers	April 2013	March 2014
1.5	Increase the number of people in receipt of a direct payment	Locality Team Managers/ Service Managers	April 2013	March 2014
1.6	Increase the number of individuals using the Kent Card as the preferred method of delivering direct payments	Locality Team Managers/ Service Managers	April 2013	March 2014
1.7	Develop a coordinated approach in delivering supported employment. Ensure as many eligible users as possible are in supported employment.	Locality Team Managers/ Service Managers	April 2013	March 2014
2	**Continue to review safeguarding arrangements**			

	to ensure the protection of vulnerable people			
2.1	Work with partners, including the police and criminal justice system to safeguard vulnerable people and, if they are victims of crime, ensure they have access to justice and support.	Locality Team Managers/ Adult Protection Coordinators	April 2013	March 2014
2.2	Use the Safeguarding Vulnerable Adults Competency Framework to evidence the competence of community teams to deal with safeguarding issues.	Locality Team Managers/ Adult Protection Coordinators	April 2013	March 2014
2.3	Reduce the number of Safeguarding Cases open beyond 6 months.	Locality Team Managers/ Adult Protection Coordinators	April 2013	March 2014
3	**Ensure services are customercentric with clear information, access, complaints processes and quality assurance**			
3.1	Review Customer Service Team and processes and implement new service model	Maureen Stirrup/Anthony Mort.	April 2013	June 2013
4	**Engage service users and others to obtain feedback on services**	**Anthony Mort/Quality Manager**	**April 2013**	**March 2014**
5	**Workforce development**			
5.1	Define an overarching workforce plan for adults with learning disabilities and mental health needs to ensure we have the right people, in the right place, with the right skills to meet business need	Chris Beaney/Mark Walker/ Cheryl Fenton	April 2013	October 2013
5.2	Develop and commence delivery of a training strategy to optimise the workforce to deliver high quality outcome focused services	Chris Beaney/Mark Walker/ Cheryl Fenton	October 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	At least 6% of eligible people with learning disabilities are in supported employment	March 2014
B	70% of eligible mental health service users in receipt of a personal budget	March 2014
C	70% of eligible people with learning disabilities in receipt of a personal budget	March 2014
D	Kent card as the preferred way in delivering direct payments to be implemented within FSC	March 2014
E	Reduced numbers of Safeguarding cases open after 6 months via Audits.	March 2014
F	Delivery of a joint workforce plan	October 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		
2		
3		

PRIORITY 6: Financial & Policy Changes		DESCRIPTION OF PRIORITY: To monitor and prepare for any legislation that may impact on financial projections and/or policy		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Continue to ensure value for money and check that every penny counts**			
1.1	Utilise the cost setting guidance to allocate funding according to individual assessed needs	Locality Team Managers	April 2013	March 2014
1.2	Ensure care reviews are undertaken in line with policy	Locality Team Managers	April 2013	March 2014
1.3	Ensure timely review (and where applicable resolution) of direct payments	Locality Team Managers	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	70% of clients allocated a personal budget utilising the cost setting guidance tool	March 2014
B	100% of clients receive an annual care review	March 2014
C	100% of DP4 undertaken	March 2014

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

SECTION D: FINANCIAL AND HUMAN RESOURCES

Financial information will not be available until after the 2013-14 budget has been agreed by County Council (projected March 2014-14)

For the Financial Resources section **Finance** will provide the required information and detail that sets out the main components of your budget by completing the table below.

FINANCIAL RESOURCES								
Divisional Unit	**Responsible Manager**	**Staffing**	**Non Staffing**	**Gross Expenditure**	**Service Income**	**Net Expenditure**	**Govt. Grants**	**Net Cost**
		£	**£**	**£**	**£**	**£**	**£**	**£**

HUMAN RESOURCES		
FTE establishment at 31 March 2014	**Estimate of FTE establishment at 31 March 2014**	**Reasons for any variance**
757.2 (HR figure Nov 2012)	757.2	

The fte estimated for 31 March 2014 does not account for the impact of any changes implemented via the staff reviews or through the delivery of transformation.

SECTION E: RISK AND BUSINESS CONTINUITY

RISKS – FSC has a risk register which is maintained and includes greater detail. The below highlights the key risks from the overarching risk register as applicable to Learning Disability and Mental Health services.	
RISKS	MITIGATION
BUISNESS CONTINUITY	
	projects completed, Newton Europe provided advice.
Need to ensure robust safeguarding arrangements are in place for Learning disability and Mental Health Services	Multi-agency safeguarding arrangements in place, peer review and safeguarding procedures. Safeguarding co-ordinators appointed. Training provided.
Financial pressures and increased demand on services	Robust financial and activity monitoring. Transformation programme in place.
Oversee the KCC/KMPT partnership agreement and changes to ways of working e.g. personalisation of services to give greater choice and control to the service user.	Developing more robust arrangements for supervision and support. More robust joint governance.
Transition arrangements and preparation for statutory changes to SEN services that will impact on ways of working.	Transition working groups in place, close liaison with colleagues in SEN services, participation and contribution to SEN pilot projects.
Financial Pressures on partner agencies for example risk of cost	Close monitoring of Continuing Health Care and Section 117

The Division has up-to-date Business Continuity Plans in order to provide essential services when faced with a business disruption. Each department has undertaken a Business Impact Analysis and produced a Business Continuity Plan. In addition, business continuity planning forms part of the contracting arrangements with our private and voluntary sector providers. Our plans provide assurance that effective risk and business continuity management is being undertaken for each service, and that there is a clear synergy between the business plan, service risk register, and business and money plan.

Business Impact Analysis is reviewed at least every 12 months, or when substantive changes in processes and priorities are identified. The availability of up-to-date plans will ensure that the Directorate can continue to operate and provide essential services, at least, to a pre-determined minimum level, in the event of a major business disruption.

The table below headlines the Division's most critical processes and the minimum level of service at which the function will be delivered following a significant business disruption. Further details regarding critical functions and their supporting resources are detailed in the Directorate's Business Impact Analysis.

CRITICAL FUNCTIONS	TIMESCALE	MINIMUM SERVICE LEVEL
Local Access Response Potential risk if the programme of modernisation of services is not sustained.	4 hours	Maintain critical access for the public and multi-agency partners to joint adult health and social care through KCC and KCHT based services including the commissioning and provision of inpatient, outpatient, care in the home, community, day services, and residential and respite services. Need to continue progress the Good Day Programme and innovative ways of working to provide opportunities for people with learning disability
Management of Contract of Service for Specialist Staff and Delegated Responsibilities (Learning Disability) Potential risk if people with learning disability and carers and Delegated Responsibilities not fully managed in services and the broader society	4 hours	Manage delegated responsibilities to KCC to provide an approved integrated Learning Disability Practitioner Service. Manage Continuing Health Care (Lead) and qualified social care staff from KCHT to support and deliver specialist services across Kent. Lead on practice and quality standards, undertaking regular audits to manage, maintain and report on performance of quality, practice and procedures, ensuring all services operate in line with NHS Standards, guidance, protocols, policies and mandates. An active Learning Disability Partnership Board and Cabinet with service delivery groups promoting for example improved health, citizenship and transition. Build community capacity.
Safeguarding Processes	4 hours	Manage safeguarding alerts regarding new or existing Service Users. Undertake Adult Protection assessment, investigation, intervention and strategy discussion including co-ordination of case conferences.
Referrals and Assessment Processes	4 hours	Manage new referrals to appropriate health or social care service, conduct priority care management, health assessments, screening, care plan and intervention for clients

		referred to health and social care professionals. Arrange appropriate services for people based on priority assessment.
Residential Respite and Day Care Operations Process	4 hours	Manage all critical Residential and Day Care operations to provide and maintain a safe/secure environment conducive to meeting the needs of staff and service users to meet their accommodation needs.
Short Term Bed Allocation Process	4 hours	Co-ordinate the planning and purchase of short term bed provision to enable short term care in residential and nursing homes, including supporting Hospital discharge process.
Operational Policy Standards	4 hours	Provide critical advice and support on care management operational policy, practice and procedures. Manage communications of policy changes and implementation.
Business Continuity and Major Emergency Incident Response and Support	4 hours	Manage Directorate incident response and co-ordination to emergency community incidents and internal service disruption, including alerting and activation of plans, rest centre response, identification of vulnerable persons, liaison with County Emergency Centre and other external partners and agencies. Provide support to maintain statutory requirements for roles set out in Major Emergency Plan and Business Continuity Plan ensuring key decisions, record keeping , debriefing and reporting are managed appropriately.
Independent Living and Support – Management of Community Equipment Services	24 hours	Case manage and overview of contract management and Service Level Agreement management for the Countywide Integrated Community Equipment Services, providing telecare/teleheath, community equipment and services to users. Ensure continuity and maintenance of systems and service networks. Carry out essential repairs to lifts and maintain items.
Client and Business Information Management	24 hours	To maintain client records and critical business information (client records, financial, contractual, systems, other information assets) and all aspects of record keeping, including hardcopy and electronic data formats (Msoft, Redcell, SWIFT, ICS, Atrium, Oracle, PNC6, ENUT), in line with information.

SECTION F: PERFORMANCE AND ACTIVITY INDICATORS	**PERFORMANCE INDICATORS TO BE UPDATED IN JAN 2013 - STEPH ABBOTTS TEAM**

Table for PERFORMANCE indicators measurable on a quarterly basis by financial year

PERFORMANCE INDICATORS – QUARTERLY BY FINANCIAL YEAR	Floor Performance Standard	2012/2013 Outturn	Comparative Benchmark	Target			
				Q1	Q2	Q3	Q4

Table for PERFORMANCE indicators measurable on a termly basis by academic year

PERFORMANCE INDICATOR – TERMLY BY ACADEMIC YEAR	Floor Performance Standard	Aut 12 Outturn	Comparative Benchmark	Target – terms end dates			
				Spr 13	Sum 13	Aut 13	Spr 14

Table for PERFORMANCE indicators measurable annually by financial year

PERFORMANCE INDICATOR - ANNUALLY BY FINANCIAL YEAR	Floor Performance Standard	2012/13 Outturn	Comparative Benchmark	Target 2013/14	Target 2014/15

PERFORMANCE INDICATOR - ANNUALLY BY FINANCIAL YEAR	Floor Performance Standard	2012/13 Outturn	Comparative Benchmark	Target 2013/14	Target 2014/15

Table for PERFORMANCE indicators measurable annually by academic year

PERFORMANCE INDICATOR - ANNUALLY BY ACADEMIC YEAR	Floor Performance Standard	2012 Outturn	Comparative Benchmark	Target 2013	Target 2014

Table for ACTIVITY indicators measurable on a quarterly basis by financial year

ACTIVITY INDICATOR	2012/13 Outturn	Comparative Benchmark	Expected range for activity				
			Threshold	Q1	Q2	Q3	Q4
			Upper				
			Lower				
			Upper				
			Lower				

SECTION G: ACTIVITY REQUIRING SUPPORT FROM OTHER DIVISIONS/SERVICES		
ACTIVITY DETAILS	EXPECTED IMPACT	EXPECTED DATE
Establishing Access to Resources Team and related procurement processes/systems including i-procurement	Procurement	April 2013
Review Purchasing Officers	Human Resources	June 2013
Review Personalisation Coordinators	Human Resources	April 2013
Review Care Manager Assistants	Human Resources	June 2013
Ensure best use of KCC owned property through review of Day and Respite services	Property	June 2013
Swift review and data clean up	ICT	April 2013
Consultation regarding informal review of respite facilities	Customer and Community Engagement	June 2013
Development of a workforce plan	Human Resources	April 2013
Development of a training plan and associated delivery	Case Management	October 2013
Development of a care management strategy	Human Resources	June 2013
Review of commissioning arrangements of transport services	Procurement/Commercial Services	April 2013
Tender for potential social enterprise or right to challenge	Procurement/Human Resources	June 2013
Mental Health Short Term Recovery Model	Procurement	April 2013
Supporting Independence pilots	Procurement	April 2013

Divisional Business Plan 2013-14

Directorate Name: Families and Social Care
Division/Business Unit Name: Specialist Children's Services

EXECUTIVE SUMMARY:
Cabinet Portfolio: Jenny Whittle – Cabinet Member for Specialist Children's Services
Responsible Corporate Director: Andrew Ireland
Responsible Director: Mairead MacNeil
Assistant Directors: Karen Graham Suzanne King Raj Bharkhada (Interim) Mark Gurrey (Interim) Philip Segurola

Kent County Council

Gross Expenditure: TBC
FTE: TBC

SECTION A: ROLE/PURPOSE OF FUNCTION

The overall purpose of the Specialist Children's Services Division is to deliver positive outcomes for Kent's children, young people and their families. This includes:

- Ensure that vulnerable children are identified early and that services are deployed effectively and speedily to meet their needs
- Provide support for children in need and their wider family
- Provide protection for children at risk of abuse or neglect
- Meet the needs of children in care, and promote permanence and stability

To successfully deliver these objectives the division must get the right balance between the following four elements:

Improvement in the quality of practice:

- Outcome focused practice
- Peer and management challenge
- Staff confidence to exercise professional judgement
- Confidence in evaluating and responding to risk
- Staff understand their role and that of partners in integrated services

Effective multi-agency working:

- Good information sharing
- Quality of partnership working
- Shared objectives and oversight

Effective use of resources:

- Productivity increase
- Overarching KPIs and outcomes to monitor performance
- Users able to shape service delivery

Outcomes for Children and Young People better than the national average:

- Children are safeguarded
- Fewer children in care
- More children adopted
- Improvement in take-up of employment
- Improvement in Health and Educational outcomes for Children in Care

The division currently consists of:

Countywide Services-

Central Referral Unit (including out of hours service) – Deals with all child contacts and enforces robust and consistent management of thresholds. The Out of Hours Service provides an emergency response outside normal working hours. The Central Referral Unit includes representatives from Police, Health and Adult Services

The Safeguarding Unit - The core purpose of the Safeguarding Unit is to provide a quality assurance service and ensure that the provision of services for vulnerable children and young people is compliant with national statutory requirements and performance standards and that safeguarding practice

across the Families and Social Care Directorate is effective. The unit is made up of four teams, each with a different focus; the Kent Safeguarding Children Board, the Education Safeguard Team, the Child Protection Team and the Children in Care and Care Leavers Team.

Family Group Conferencing (countywide service) – Ensures all children all children in Kent at risk of entering care are given the opportunity of having a Family Group Conference (partnership and decision-making process that engages the child's family and family network with Children's Social Services and other service providers in making safe plans for the child's care)

Countywide Fostering Service- Responsible for recruiting and training Foster Carers across the county

Adoption Service - Provides a comprehensive social work service under the Adoption and Children Act (2002).

Service for Unaccompanied Asylum Seeking Children (SUASC) - Undertakes the Local Authority's statutory duty to assess and, if satisfied that the young person is a child alone in the country, to provide a looked after service under Section 20 of the Children Act 1989.

Disabled Children's Services and Short Breaks- provides services for children whose disability is complex or profound.

Virtual School for Children in Care - Actively works with young people, professionals and settings to optimise the education, health and life chances of all Kent Children in Care and Care Leavers.

Area Based Specialist Children's Services

Family Support Teams - Deliver frontline services to children and families across Kent, in particular the coordination of multi-agency child protection work and the management of child protection referrals across Kent. Statutory tasks include: Undertaking child protection investigations, undertaking initial and core assessments, undertaking parenting assessments, developing and driving child protection plans, initiating legal proceedings to apply for a range of orders including admitting children to the care system.

Children in Care teams - Develop and drive the Child in Care plan. Undertake lead professional for Children in Care and discharge parental responsibilities in partnership with parents dependent upon the legal status of the child. Ensure that care leavers are supported by specialist 16+ service, delivered by Catch 22.

Fostering Support- Delivering high quality support for foster carers.

Preventative Services

Preventative Services - Ensure that vulnerable children are identified early and that services from relevant agencies are deployed effectively and speedily to meet their needs through the Common Assessment Framework.

Integrated Process – Development and delivery of integrated processes (Single Point of Access, Common Assessment Framework, lead professional, team around child, child/family/school) to ensure county wide consistency and equity.

Children's Centres – Management of Children's Centres, ensuring that they are delivering the core offer effectively and are targeting children and families that are hardest to reach.

SECTION B: CONTRIBUTION TO MTP OBJECTIVES
All activity is executed in line with the Kent County Council's Equality Strategy across the priority outcomes of the Equality Framework for Local Government (EFLG) and where possible and appropriate the KCC Environment Policy and standard ISO 14001. All priorities involve customer insight and comply with the 'duty to involve'. **This includes the involvement of children and young people and their carers to inform the design and delivery of services, particularly vulnerable groups and seldom heard children and young people e.g. Children in Care and disabled children.** **The Division's work is also influenced by the three ambitions set out in Bold Steps for Kent, the Medium Term Plan to 2014/15. The information below describes how the Specialist Children's Services work contributes to the overall objectives.**
TACKLE DISADVANTAGE: **Ensure the most robust and effective child protection arrangements** • Support the delivery of the Kent Safeguarding and Children in Care Improvement Plan – Putting Children First. • Ensure referrals are assessed quickly and appropriately, with swift intervention where necessary. **Improve services for Children in Care** • Ensure that we look after the right children in the right placements through robust care planning • Promote greater stability in foster care placements through targeted recruitment and support for our carers. • Improve educational outcomes for Children in Care. **Support families with complex needs and increase the use of community budgets** • Promote robust planning for CIN and their families • Support the roll out of the Troubled Families Programme to communities across Kent.
PUT THE CITIZEN IN CONTROL: **Support the transformation of Specialist Children's Services in Kent** • Improve engagement of children and their families. **Ensure all children meet their full potential** • Reduce the attainment gap between Children in Care and the general population
HELP THE ECONOMY GROW: **Improve how we procure and commission services** •Improve our understanding of the range of needs of children and young people and commission services to meet needs

SECTION C: PRIORITIES, ACTIONS, PROGRAMMES, PROJECTS, MILESTONES, KEY OR SIGNIFICANT DECISIONS

Management Teams are required to regularly review progress against the actions and milestones set out in the tables below. Monthly progress may be appropriate for individual services to review their business plan progress, and quarterly may be appropriate at the Divisional level. Formal reporting of progress by Division to Cabinet Committees is required twice a year, at the mid-year point and after the year-end.

This Business Plan is intrinsically linked to Phase 3 of the Kent Safeguarding and Looked After Children Improvement Plan August 2012-August 2013. Where appropriate, links to the Improvement Plan are highlighted in order to provide greater detail around deliverables and targets.

The Corporate Director is authorised to negotiate, settle the terms of, and enter the following agreements/projects:

PRIORITY 1: Safeguarding and Protection		**DESCRIPTION OF PRIORITY: Deliver high quality rigorous and consistent frontline practice to safeguard children and young people. This covers the prevention category of the 5 Ps.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Ensure the most robust and effective child protection arrangements** Improvement Plan 2.2, 5.1, 5.2			
1.1	Respond to and implement the revised Working Together to Safeguard Children	Mark Gurrey	April 2013	May 2013 (review)
1.2	Develop and promote effective and focussed child protection planning	Mark Gurrey	January 2013	July 2013
2	**Make sure that children and young people are safe and stay safe in every setting** Improvement Plan- 5.1			
2.1	Delivery of Phase 3 Improvement Plan actions	Mairead MacNeil	April 2013 / August 2012	August 2013
2.2	Develop and Implement post Ofsted inspection action plan	Mark Gurrey	January 2013	June 2013 (review)
2.3	Reduce the number of children who become subject to a Child Protection plan for a second	Mark Gurrey	April 2013	November 2013

	or subsequent time through robust assessment and planning processes			
3	**Increase the awareness and understanding that keeping all children and young people safe is the responsibility of everyone in the community** Improvement Plan- 5.2			
3.1	Review the Central Referral Unit	Karen Graham	February 2013	
3.2	Support and develop the work of the Kent Safeguarding Children's Board	Mark Gurrey	December 2012	Autumn 2013 (review)
4	**Ensure consistent application of safeguarding thresholds** Improvement Plan- 2.1			
4.1	Promote understanding across all partners of thresholds for accessing statutory Specialist Children's Services	Karen Graham	Ongoing	June 2013 (review)

KEY MILESTONES		DATE (month/year)
A	Completion of actions in Phase 3 of Improvement Plan	August 2013
B	Implementation of Kent Safeguarding Children Board Business Plan	April 2013
C	Review of Central Referral Unit practice	April 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		
2		
3		

PRIORITY 2: Early Help, Intervention and Prevention.		DESCRIPTION OF PRIORITY: Provide a streamlined continuum of early help, intervention and prevention services to empower and enable children and families. This covers the prevention and people categories of the 5 Ps.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Enhancing the responsiveness and inclusivity of universal services that give families the right help early enough to resolve difficulties and reduce the need for further intervention** Improvement Plan- 3.1			
1.1	Work with universal services and other providers to provide inclusive support	Karen Graham	April 2013	Autumn 2013 (review)
2	**Improving care planning and outcomes for Children in Need** Improvement Plan- 5.1			
2.1	Improve the quality of Child In Need planning to ensure children are appropriately supported to prevent an escalation to Child Protection	Mark Gurrey	January 2013	June 2013 (review)
2.2	Practitioners to ensure chronologies are appropriately completed so that plans are based upon the history of the family and are meaningful	Assistant Directors	April 2013	Autumn 2013 (review)
3	**Improve engagement of partners' front line staff in the Common Assessment Framework process** Improvement Plan- 3.2			
3.1	Contribution to the Troubled Families agenda	Karen Coffey	April 2013	Autumn 2013 (review)
3.2	Contribution to the Kent Integrated Adolescent Support Service	Karen Coffey	April 2013	Autumn 2013 (review)

3.3	Improve the quality and consistency of Common Assessment Framework's/Team Around the Families' recording	Karen Graham	April 2013	Autumn 2013 (review)
4	**Improve engagement of children and young people – including initial assessment** Improvement Plan 4.5			
4.1	Involve young people and their families in shaping services	Tony Doran	April 2013	Autumn 2013 (review)
4.2	Engage and work with families to build their resilience	Assistant Directors	April 2013	Autumn 2013 (review)
5	**Improving the consistency and cohesive universal service offer for young people to help support them to make a positive contribution to society**			
5.1	Clear thresholds that are understood and consistently applied, between different services, with universal and targeted services working together	Mark Gurrey	April 2013	Autumn 2013 (review)
6	**Ensuring that children and their families have access to timely, effective and responsive health care that gives them the best start in life and resolves health needs as they arise**			
6.1	Promote the engagement of a vibrant and diverse Voluntary Community Sector in commissioning processes, including market development	Helen Jones	April 2013	Autumn 2013 (review)
KEY MILESTONES				DATE (month/year)
A	Engagement with families through the Troubled Families programme			Autumn 2013 (review)
B				
C				

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		
2		
3		

PRIORITY 3: Ensure we respond to the needs of children and young people with complex needs and disabilities.		**DESCRIPTION OF PRIORITY: Develop high quality child and family centred services which promote personalisation and respond to the needs of children and young people with complex needs and disabilities. This covers the people category of the 5 Ps.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Further develop the Disabled Children's Services**			
1.1	Improve robust assessment and planning processes	Philip Segurola	February 2013	Autmn 2013 (review)
1.2	Ensure that Disabled Children's Services reflect the needs and views of children with complex needs and disabilities and their families	Philip Segurola	April 2013	July 2013 (review)
2	**Engage Health and Wellbeing Board to ensure health reforms respond effectively to the needs of children in particular children with complex needs and disabilities**			
2.1	Work with health and wellbeing boards on the health reforms related to Disabled Children's Services	Philip Segurola	Ongoing	July 2013 (review)
3	**Ensure the following services or providers are delivering to improve outcomes for children with complex needs and disabilities**			
3.1	Special Educational Needs Pathfinder- Develop joint plans with Health and Education and the personal budgets	Philip Segurola	September 2012	September 2013
3.2	Multi-Agency Specialist Hub (MASH)- Complete the moving in of Health staff and develop joint working protocols between all staff and parents	Philip Segurola	January 2013	Autumn 2013 (review)
3.3	Child and Adolescent Mental Health Service (CAMHS)- Develop challenging behaviour services for children and young people with complex needs	Philip Segurola/Helen Jones	December 2013	September 2013
3.4	Child and Adolescent Mental Health Service (CAMHS)-	Philip Segurola/Helen Jones	October 2012	March 2013

	Ensure Emotional Wellbeing services include disabled children			
KEY MILESTONES				DATE (month/year)
A	Full engagement with Health Staff			TBC
B	Child and Adolescent Mental Health Service (CAMHS services address needs of disabled children			Autumn 2013 (review)
ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?				ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1				
2				

PRIORITY 4: Effective Support to Children in Care.		DESCRIPTION OF PRIORITY: Deliver effective support to Children in Care and improve their outcomes.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Increase Children in Care permanency and stability to ensure Children In Care feel safe and nurtured in a home setting** Improvement Plan 4.1, 4.4			
1.1	All children in care have high quality care plans, assessments and Personal Education Plans	Suzanne King/Mark Gurrey	April 2013	Autumn 2013 (review)
2	**Improve the quality of practice (including supervision, care plans recording, assessment)**			
2.1	Ensure the health needs and well being of Children in Care and young people are assessed and result in appropriate intervention Improvement Plan 4.2	Suzanne King	April 2013	Autumn 2013 (review)
2.2	Children In Care Service Managers take the responsibility to ensure that all Children In Care have care plans, assessments, and Personal Education Plan's Improvement Plan 4.3	Suzanne King	April 2013	May 2013 (review)
2.3	Ensure a good range of placements are available to meet the needs of children and young people close to home where it is safe to do so	Suzanne King	April 2013	Autumn 2013 (review)
3	**Implement the participation plan** Improvement Plan 4.5			
3.1	Ensure a wider range of children in care are routinely made aware of how they can contribute to the development of the service or make complaints	Tony Doran	April 2013	April 2013
KEY MILESTONES				DATE

		(month/year)
A	Implement the participation plan for children in care	April 2013
B		
C		

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 5: Better use of Resources		**DESCRIPTION OF PRIORITY: Ensures we use our resources in the most appropriate way, and develop where needed to deliver effective and efficient services for children and young people. This covers the procurement, productivity, and partnership categories of the 5 Ps.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Workforce Development** Improvement Plan- 1.3			
1.1	Workforce development plans, improved supervision and sharing of best practice to enhance staff expertise and confidence further to raise quality of practice	Raj Bharkhada	April 2013	August 2013
1.2	Review supervision training programme to ensure effectiveness	Raj Bharkhada	April 2013	Autumn 2013 (review)
1.3	Procedures put in place for effective talent management and succession planning	Raj Bharkhada/Karen Ray	August 2012	Autumn 2013 (review)
2	**Staff recruitment and retention, sharing best practice and culture** Improvement Plan- 1.2			

2.1	Develop and implement transformational plan	Raj Bharkhada	April 2013	Autumn 2013 (review)
2.2	Review recruitment activity and take corrective action to address areas of underperformance identified by performance indicators	Karen Ray/Raj Bharkhada	April 2013	May 2013 (review)
2.3	Review retention activity based on retention statistics	Karen Ray/Raj Bharkhada	April 2013	May 2013 (review)
KEY MILESTONES				DATE (month/year)
A	Review of recruitment activity	Karen Ray/Raj Bharkhada		April 2013
B	Further drive to recruit permanent social workers	Karen Ray/Raj Bharkhada		Autumn 2013 (review)

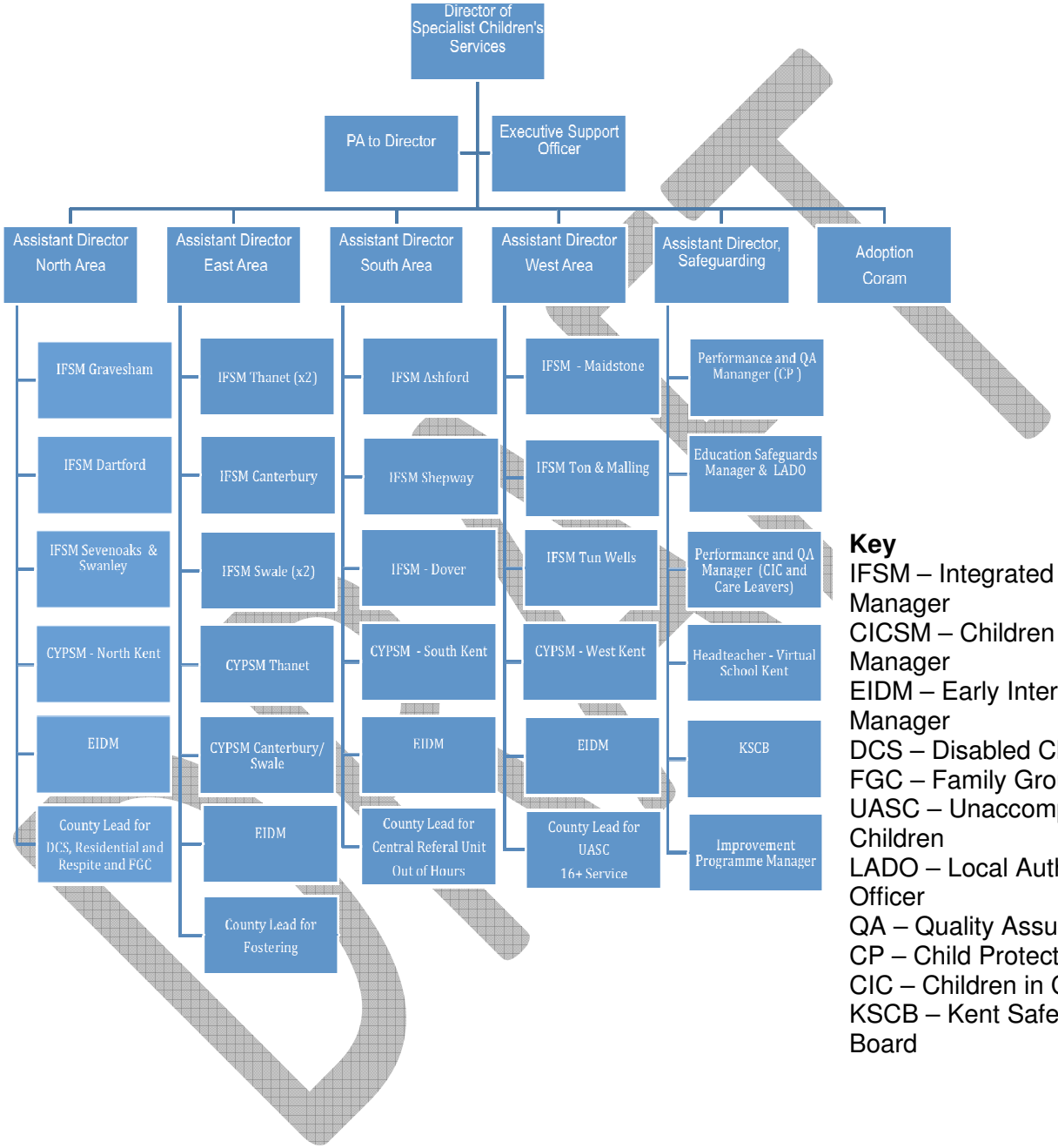
ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?	ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	

SECTION D: FINANCIAL AND HUMAN RESOURCES

For the Financial Resources section **Finance** will provide the required information and detail that sets out the main components of your budget by completing the table below.

FINANCIAL RESOURCES								
Divisional Unit	**Responsible Manager**	**Staffing**	**Non Staffing**	**Gross Expenditure**	**Service Income**	**Net Expenditure**	**Govt. Grants**	**Net Cost**
		£	**£**	**£**	**£**	**£**	**£**	**£**

HUMAN RESOURCES		
FTE establishment at 31 March 2013	**Estimate of FTE establishment at 31 March 2014**	**Reasons for any variance**



Key

IFSM – Integrated Family Service Manager
CICSM – Children in Care Service Manager
EIDM – Early Intervention Delivery Manager
DCS – Disabled Children's Service
FGC – Family Group Conferencing
UASC – Unaccompanied Asylum Seeking Children
LADO – Local Authority Designated Officer
QA – Quality Assurance
CP – Child Protection
CIC – Children in Care
KSCB – Kent Safeguarding Children Board

SECTION E: RISK & BUSINESS CONTINUITY

RISKS	
RISKS	**MITIGATION**
Failure to meet Ofsted improvement targets within the designated timescales	• Robust planning has been carried out to clarify targets and delivery timescales. • The management of the Programme has been robust, and frequent meetings to monitor progress and action upon any deviations have been taking place. • Frequent communications have also been sent to Programme stakeholders to ensure the importance of meeting these targets is continually reinforced. • Performance management figures indicate the Programme is on track to meet its targets.
It may prove difficult to recruit experienced social workers to both temporary and permanent positions.	• A new recruitment campaign to target management and case-holding vacancies continues to be rolled out. The recruitment microsite has been updated, and the results are being monitored. • The Recruitment and Retention Strategy has been revisited and honed to ensure the package offered to social work staff (both new starters and existing staff), in terms of pecuniary and non-pecuniary (e.g. training) benefits, is competitive and appealing. The Strategy and 'Compelling Offer' is now being reviewed to determine the impact they is having on recruitment and retention rates. Options for necessary responses will be discussed with the Director of Specialist Children's Services and the Director of Families and Social Care. • Recruitment events are taking place in late 2012 and early 2013, aimed at raising the profile of Kent County Council's children's social services division, targeting social workers and aspiring social workers. The outcomes of these events will be monitored, and used to inform subsequent recruitment drives. • Action is also being taken to engage with our existing agency social workers to encourage them to join Kent County Council as substantive employees.

Paucity of Experienced Managers. There may a scarcity of good, experienced social work managers at all levels following the restructure, which could mean insufficient capacity within the workforce to deliver the required levels of Service	• The Recruitment and Retention Strategy offers a variety of benefits to experienced managers as well as other social work staff. • Kent County Council have employed TMP, a world-leading recruitment advertising agency, to design a bespoke campaign to attract social workers and managers from competing authority areas to work in Kent. • Kent County Council are committed to maintaining adequate staffing levels to attain levels of service delivery, and shortfalls in the recruitment of permanent members of staff will be filled by agency workers until such a time as staff with the requisite balance of skills and experience can be recruited. • A micro-site has been developed to assist in attracting managers and experience staff to Kent.
Failure to engage children and young people with regard to providing feedback on the quality of services that they receive.	• A Participation Plan (developed in consultation with the Children in Care Council) has been formulated to ensure that a wider range of children in care are routinely made aware of how they can contribute to the development of the service or make complaints. This Plan is being implemented during Phase 3 of the Improvements. • Our Children and Young People's Council membership is being extended to include a wider representation of the children in care population. The Council is also being promoted to raise its profile amongst the community. • Measures are being implemented so that Children in Care and young people are empowered to inform decisions and shape provision for themselves and their peers.
£1M has been made available to deliver the Improvement Programme in 2012/13. Additional funding has also been sought from CIB to fund Improvement actions. More funds are likely to be required to complete improvement related work before the end of the Programme.	• Improvement actions are currently planned to come just within the forecasted budget for the 2012/13, or with some overspend depending on the revenue implications of some 2011/12 Improvement Projects, (currently being negotiated with the relevant directorates/areas). • Additional resources have been obtained from grant bodies, which will assist to cover any shortfall, and the budget position is regularly discussed with the Director of Specialist Children's Services and Director of Families and Social Care. An additional £1.9M has been set aside to pay for the workforce strategy.

	• Cabinet and the Corporate Management Team have pledged to make resources available to deliver the improvements to children's services.
The introduction of the new ICS system will necessitate a period of staff training and data migration. This may cause dips in performance impacting upon staffs' ability to meet their allotted targets.	• The risk of performance 'dips' has been significantly reduced following the introduction of the tracker tool and the clearing out of old data from the system. • The ICS Project Team are producing a robust plan to prepare for the migration of data across to the new system; a package of training and a timetable for delivery is being factored into the process to reduce the risk of a performance dip. • The ICS Board has been established and meets fortnightly to oversee the procurement and integration of the new system. • Reports are sent to the internal improvement governing body (Programme Board) on a monthly basis, ensuring issues and risks are escalated and actioned. • A robust project plan has been produced to manage the delivery process, and staff have been actively involved in scoping the requirements for the new system.
The KSCB's process of implementation and challenge may be insufficient to achieve the improvements necessary to safeguard C&YP	• The Kent Safeguarding Children Board Business Unit has been reconfigured to offer more effective support to the Board • The Chair has doubled her input into the County and to Board business to ensure the level of challenge and scrutiny is increased and is effective • The Chair has specifically taken on the chairing of the Quality and Effectiveness Group to ensure that makes a more significant contribution • A new Quality Assurance Framework and dataset is being constructed for the Board to improve its challenge to partner agencies in relation to their safeguarding activities

BUISNESS CONTINUITY

The Division has up-to-date Business Continuity Plans in order to provide essential services when faced with a business disruption. Each department has undertaken a Business Impact Analysis and produced a Business Continuity Plan. In addition, business continuity planning forms part of the contracting arrangements with our private and voluntary sector providers. Our plans provide assurance that effective risk and business continuity management is being undertaken for each service, and that there is a clear synergy between the business plan, service risk register, and business continuity plan.

Business Impact Analysis is reviewed at least every 12 months, or when substantive changes in processes and priorities are identified. The availability of up-to-date plans will ensure that the Directorate can continue to operate and provide essential services, at least, to a pre-determined minimum level, in the event of a major business disruption.

The table below headlines the Division's most critical processes and the minimum level of service at which the function will be delivered following a significant business disruption. Further details regarding critical functions and their supporting resources are detailed in the Directorate's Business Impact Analysis.

CRITICAL FUNCTIONS	TIMESCALE	MINIMUM SERVICE LEVEL
Local Access Response	4 Hours	Maintain critical access for the public and multi-agency partners to children's social care services including the Central Referral Unit, Out of Hours Emergency Access, commissioning and provision of services for the protection of children and families at risk, care in the home and education, equipment and adaptations, day services and short-break residential services.
Case Management and Assessment Processes	4 hours	Manage priority information regarding new and existing cases including Common Assessment Framework. Undertake assessment of needs, risk assess and prioritise and allocate in order of urgency**.** Co-ordinate services to deliver to agreed plans. Manage assessment and placement processes. Provide welfare reports and attend private court proceedings at request of courts. Attend court proceedings in support of child, family or carer providing information, advice and guidance.
Safeguarding Processes	4 hours	Manage safeguarding alerts regarding new or existing Service Users. Undertake assessments, strategy discussion and manage decisions on further action required including investigation and intervention, case conference requirements and multi-agency participation. Provide specialist advice on all safeguarding functions.
Client and Business Information Management Processes	4 hours	Maintain client records and critical business information (client records, financial, contractual, systems, other information assets) and all aspects of record keeping, including hardcopy and electronic data formats, in line with Information Governance procedures.
Residential and Day Care Operations Services	4 hours	Manage all critical in-house and commissioned residential accommodation, community accommodation, Short Break Units, Children's Centre and Nursery operations to provide and maintain a safe/secure environment conducive to meeting

		the needs of staff and service users to meet their accommodation needs.
Adoption Process	4 hours	Manage county adoption process including adoption support visits, Special Guardianship Support and Child in Need service to adopters. Provide information, advice, guidance and counselling.
Out of Hours Service	4 hours	Manage Out of Hours Service to Kent and Medway receiving new and urgent referrals for children's and adults social services including Telecare response. Manage priority referral, assessment and safeguarding processes.
Fostering Services	24 hours	Manage fostering service assessment and placement, supervision of foster carers. Develop and maintain Performance and Development Plan and appropriate training needs analysis. Manage contract for supply of nursery and therapeutic equipment to the homes of foster carers.

It should be noted that the risks for the Specialist Children's Services division are common to the Families and Social Care directorate level risks, as well as some corporate risks regarding Children's Safeguarding and management of demand.

SECTION F: PERFORMANCE AND ACTIVITY INDICATORS

Table for PERFORMANCE indicators measurable on a quarterly basis by financial year

PERFORMANCE INDICATORS – QUARTERLY BY FINANCIAL YEAR	Floor Performance Standard	2012/2013 Outturn	Comparative Benchmark	Target			
				Q1	Q2	Q3	Q4
Children subject to Child Protection Plan for a second time							
Number of Children in Need with Child in Need plans							
% of Disabled Children with Complex Needs on a Child Protection Plan							
% of case holding posts							
Percentage of children who wait less than 21 months between becoming Children in Care and being Placed for Adoption							
Percentage children in care in fostering placements							
Children in Care Placement stability: Same placement for last 2 years							
Percentage of TAFs closed where outcomes achieved or closed to single agency support							
Percentage of Specialist Children's Services cases closed that have been stepped down to Common Assessment Framework/ Preventative Services							
Percentage of children and young people living in poverty							
Prevalence of breastfeeding at 6-8 weeks from birth (%)							

Table for PERFORMANCE indicators measurable annually by financial year

PERFORMANCE INDICATOR - ANNUALLY BY FINANCIAL YEAR	Floor Performance Standard	2012/13 Outturn	Comparative Benchmark	Target 2013/14	Target 2014/15
Number of Children in Need per 10,000 population under 18 (includes Child Protection and Children in Care)					
Number of disabled children whose families receive Direct Payments					

Table for PERFORMANCE indicators measurable annually by academic year

PERFORMANCE INDICATOR - ANNUALLY BY ACADEMIC YEAR	Floor Performance Standard	2012 Outturn	Comparative Benchmark	Target 2013	Target 2014
Number of permanent exclusions from school – Children in Care					

Table for ACTIVITY indicators measurable on a quarterly basis by financial year

ACTIVITY INDICATOR	2012/13 Outturn	Comparative Benchmark	Expected range for activity				
			Threshold	Q1	Q2	Q3	Q4
Total number of cases waiting - snapshot (CAMHS Needs Assessment)			Upper				
			Lower				
			Upper				
			Lower				

SECTION G: ACTIVITY REQUIRING SUPPORT FROM OTHER DIVISIONS/SERVICES (For example Property, ICT, Business Strategy, Human Resources, Finance & Procurement, Planning & Environment, Public Health, Service Improvement, Commercial Services, Governance & Law, Customer Relationships, Communications & Community Engagement or other Divisions/Services)		
ACTIVITY DETAILS	EXPECTED IMPACT	EXPECTED DATE
ICS development	IT input	May 2013
Workforce development	HR	
Delivery of the Ofsted Improvement Plan	Service Improvement, ELS, Communications, Business Strategy	TBC
Kent Troubled Families Programme	Service Improvement, ELS, Business Strategy.	Throughout 2013/14
Kent Integrated Adolescent Support Service	Service Improvement, ELS	Throughout 2013/14
Public Health preventative and tackling inequalities agenda	Public Health, Business Strategy.	Throughout 2013/14

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Divisional Business Plan 2013-14

Directorate Name: Families and Social Care
Division/Business Unit Name: Strategic Commissioning

EXECUTIVE SUMMARY:
Cabinet Portfolio: Graham Gibbens (Adults) Jenny Whittle (Children)
Responsible Corporate Director: Andrew Ireland
Responsible Director: Mark Lobban
Head(s) of Service: Nick Sherlock (Adult Safeguarding) Christy Holden (Commissioning Adults Accommodation) Emma Hanson (Commissioning Adults Community Support) Helen Jones(Commissioning Children) Maureen Robinson (Performance and Management Information - Children) Steph Abbott (Performance and Information Management Adults)
Gross Expenditure: TBC
FTE: 177

SECTION A: ROLE/PURPOSE OF FUNCTION

The Health and Social Care sector is facing unprecedented change. In the future every aspect of social care provision, including how we commission services will be transformed. The Strategic Commissioning Division came into being September 2011 following an extensive KCC wide restructure. There was a further comprehensive review across Children and Adult contracting/ commissioning functions last year, with a new structure commencing on 1st October 2012. The purpose of the new commissioning function is to improve outcomes and quality of life for vulnerable adults, children and young people and carers in Kent, transforming the way social care services are delivered. We work closely with Health, District Councils, other KCC Directorates and the private and voluntary sector as well as service users and carers to ensure that services are efficient, effective and easy to access so that people, not organisations are at the centre of everything we do.

- For Adults the Division will drive forward the Transformation Programme, currently the largest single change programme Kent County Council is undertaking and will support FSC's contribution to the £200 million reduction in spend that KCC must achieve by 2015. We will do this by commissioning and procuring services within the themes of Transformation.
- For children our mission is to improve outcomes for children, young people and their families and to ensure the right services are provided at the right time, right place and at the right cost. We will ensure the effective commissioning of services to meet statutory duties and the delivery of Kent's strategic priorities as contained within Every Day Matters and Kent's Safeguarding and Looked After Children Improvement Plan – Putting Children First and the supporting Early Intervention and Preventative Strategy.

The Strategic Commissioning Division supports the delivery of the following Social Care priorities:

Prevention

- Improve public information to give people more information about independence, choice and control.
- Promote enablement and target interventions so that fewer people become dependent on long term care services.
- Build community capacity and develop more inclusive access and participation.
- Improve access to services for carers.
- Further promote the use of assistive technology and other equipment to enable people to live independently.
- Investment in early help, early intervention and prevention services.
- Review and reform of Children's Centre provision.
- Support the Troubled Families Programme and the Kent Integrated Adolescent Support Service.
- Contributing to public health preventative and tackling inequalities agenda.
- Prevent escalation of children and young people to specialist services where it is safe to do so.

Productivity

- Continue to develop and implement the Transformation Programme in adults to identify new ways of working.
- Review commissioned services to ensure best value for money and improved outcomes for service users.
- Identify opportunities for joint work with partner agencies to reduce any duplication.
- Review cost effectiveness of commissioned services.
- Integrated and child centred service development, commissioning and delivery.
- Delivery of Liquid Logic IT system changes.

Partnership

- Work with the new CCGs to ensure coherent processes and systems across health and social care and to identify opportunities for integrated commissioning and working.
- Work with housing providers to increase housing choices for older and disabled people.
- Work through the Kent Learning Disability Partnership Board to improve delivery on key areas for people with disability.
- Work with KMPT to improve outcomes for service users and promote personalisation.
- Co – produce sustainable changes strategies with a wide range of partners, include those who use services, those who provide services and our health colleagues
- We will work with the voluntary and community sector to deliver in partnership services for young people.
- The local joint commissioning board arrangements will enable partnership working for services for young people.
- Engage with Health and Wellbeing board to ensure health reforms respond effectively to the needs of children in particular those with SEN and disability.

Procurement

- Manage the market to ensure value for money and to provide choice including for people on direct payments.
- Develop commissioning plans for specific service areas e.g. accommodation solutions, community services, or children's services to determine if a tendering process is required and then implement.
- Develop the access to resources arrangements to purchase services at the best price and quality.
- Commission Integrated services for better value that meet the needs of service users.
- Jointly commission with health to address gaps in services for vulnerable groups
- Review the impact of commissioned services for value for money
- Develop a resource strategy for shifting resources to early intervention and prevention services.
- Engagement with a diverse VCS in commissioning processes.

People

- Further promote personalisation giving people genuine choice and control over their lives.
- Continue to review safeguarding arrangements to ensure the protection of vulnerable people.
- Ensure services are customer-centric with clear information, access, complaints processes and quality assurance.
- Engage service users and others to obtain feedback on services

- Involve young people and their families in shaping service development, commissioning and evaluation
- Workforce Development, including supervision and sharing of best practice.

Financial & Policy Challenges

- Continue to ensure value for money and check that "every penny counts".
- Progress work on the integration of health and social care services.
- Implement the Transformation Programme.
- Delivery of Improvement Plan actions
- Develop inspection preparation plans and post inspection action plans
- Delivery of MTFP savings

Our Structure

The Families and Social Care Strategic Commissioning Division has 4 functions currently delivered through 6 units:

A. Safeguarding

Adults' Safeguarding Unit

B. Commissioning

1. Adults' Commissioning
2. Children's Commissioning.

C. Performance and Information Management

3. Performance and Management Information Unit–Children
4. Performance and Information Management – Adults

D. Transformation Programme

Delivering strategic oversight and Directorate wide support to the Transformation Programme.

An overview of the functions of our 6 units:

A. Adult Safeguarding Unit

Keeping vulnerable adults free from harm and children safe continues to be our main priority and of paramount importance. The County Council has maintained a strong focus on and scrutiny of safeguarding during 2012-13 and this approach will continue through 2013-2014. The work of the Adults' Safeguarding Team is critical to delivering the County Council's key objective presented in Bold Steps for Kent and the Adults' Safeguarding Plan.

Kent County Council is committed to ensuring that people in situations which could put them at risk of abuse and danger receive the support they need to maintain their personal safety and independence. Safeguarding is a major priority for us. Through Multi-Agency Public Protection Arrangements and the Multi-Agency Safeguarding Vulnerable Adults Executive Board, we have in place effective adult protection processes which safeguard vulnerable adults effectively. Kent County Council takes a personalised approach to safeguarding. Raising awareness amongst members of the community about safeguarding is key.

The functions of the Adult Safeguarding Unit include:

- Quality assurance work for senior managers and Members, including audits
- Safeguarding policy, procedure and risk management including complex investigations and Serious Case Reviews
- Analysing trends in adult safeguarding and developing new initiatives based on this
- Developing Adult Safeguarding policy including responses to national consultations
- Hosting and supporting the Safeguarding Vulnerable Adults Multi-Agency Executive Board and related Multi-Agency training
- Compliance and best practice with Mental Capacity Act and Deprivation of Liberty Safeguards
- Care Quality Commission response and relationship management, including Risk Strategy meetings
- Supporting the adult element of the CRU

The unit provides the Families and Social Care (FSC) Directorate Management Team and the Cabinet Member for Adult Social Care and Public Health with an independent quality assurance and scrutiny function. Strong governance arrangements are in place, with reporting lines from the Corporate Management Team and the Cabinet Member for Adult Social Care and Public Health through to Locality Teams. The Adult Safeguarding Unit implements a programme of practice and quality audits. Lessons learnt from internal and external audits are used to inform and improve practice and also feed into the FSC Strategic Adult Safeguarding action plan.

In 2012 the Adult Safeguarding Unit facilitated a Peer Review undertaken by Essex County Council. The overall conclusion of the Peer Review was that the vulnerable people of Kent are well served by Kent County Council and its safeguarding services

B. Commissioning

Strategic commissioning effects changes in the supply and delivery of services to a population in order to meet the needs of that population and to support local and national policy objectives. Strategic commissioning can be thought of as having four key elements - analysis, planning, doing and reviewing.

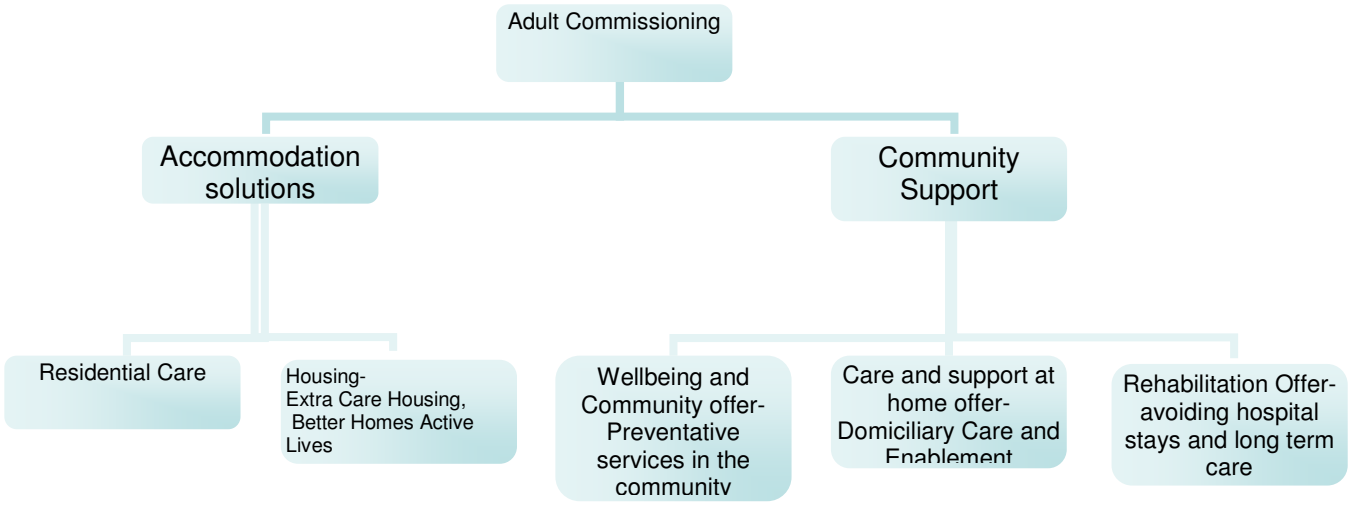
All activity is executed in line with the Council's Procurement Strategy "Spending the Council's Money", Kent County Council's Equality Strategy across the priority outcomes of the Equality Framework for Local Government (EFLG), customer insight and complying with the 'duty to involve', including the involvement of Service users, their carers, and Children and young people to inform the design and delivery of commissioned services, and where possible and appropriate The Kent Compact and KCC Environment Policy and standard ISO 14001 .

The new Strategic Commissioning Structure was implemented on 1st October 2012.

Strategic commissioning has been organised into 3 categories,

- Adults' Accommodation Solutions
- Adults' Community Support
- Children

Function of the Adults Commissioning Unit



FSC is developing a robust commissioning function supporting vulnerable adults in Kent. 85%- 90% of services are currently provided are delivered through contracts or grants with external agencies. The function of the unit is to effectively commission services that support people to remain independent for as long as possible, as set out in Bold Steps for Kent and the Transformation Blueprint

Our work is led by the themes of the Transformation Blueprint:

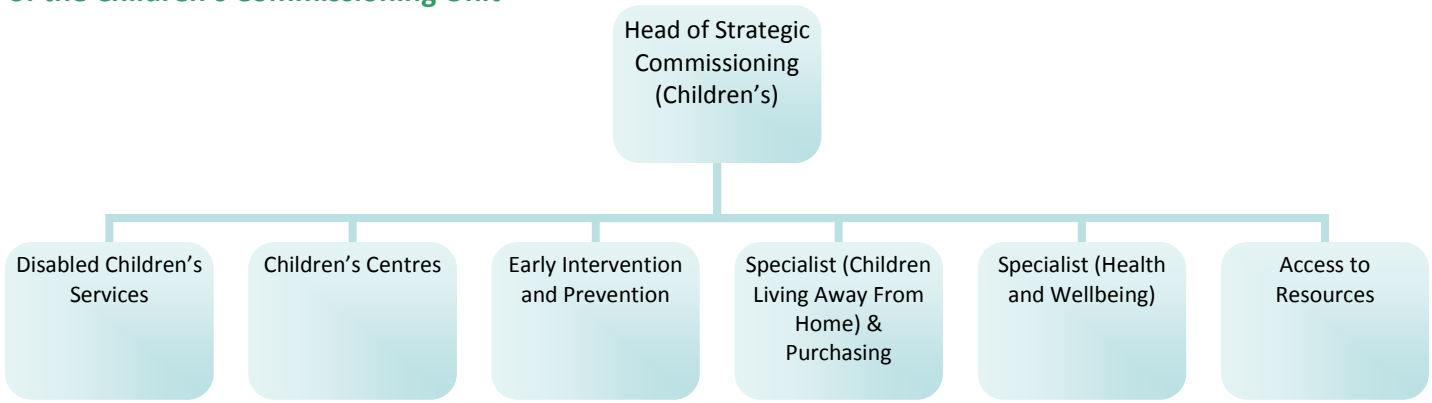
- Prevention, independence and wellbeing: Enabling people to find solutions that meet their needs.
- Support recovery, encouraging independence: Support that maximises the opportunity to recover prior to any long term care decisions.
- Support at home and in the community: Support and activities that encourage independence and prevent social isolation.
- Place to live: More options for people to live independently where they choose.
- Every penny counts: Providing value for money in everything we do.
- Doing the right things well: Ensuring the right processes are in place and applied consistently and effectively.

Local authorities also have a lead responsibility:

- in commissioning services for people who have not taken direct control of their funding through Direct Payments and personal budgets;

- for those who have Direct Payments or personal budgets, in helping to ensure the availability of appropriate support and a range of opportunities from which they can commission their own support in order to enable them to achieve their ambitions and aspirations.
- To have consideration for those who are not eligible for social care services but may need to be supported with information, advice and guidance.

Function of the Children's Commissioning Unit



The **Children's Commissioning Unit** provides the strategic direction and practical support for the delivery of the commissioning function across children's social care ensuring that the organisation is able to deliver its strategic priorities and fulfil its statutory obligations. The vision of the unit is to drive, promote and support transformational change through strategic commissioning to ensure the provision of a range of high quality, cost effective, outcome based services for children, young people and their families. The unit ensures that commissioned services achieve best outcomes for children, young people and their families in the most efficient, effective, equitable and sustainable way through rigorous planning, needs analysis and evaluation, impact assessments, performance management and contract/market development and negotiation.

<u>The unit will execute its role through:</u>

- Ongoing assessment, review and performance management of children's commissioned services to ensure effectiveness, VFM and delivery of MTFP efficiency savings
- Processes for decommissioning of services as appropriate/ necessary
- Identification and development of opportunities for joint commissioning and planning to ensure best outcomes and cost efficiency
- Improved processes for engaging the VCS and facilitating/developing a market that is responsive to need and able to creatively meet demand
- Delivery of solutions to improve outcomes for children, young people and their families e.g. the development of an Access to Resources Team to co ordinate earlier and improved use of services to achieve better outcomes for children in care
- Service Transformation Review to improve outcomes for children, young people and their families

- Effective procurement practice, commitments and contractual arrangements

C. Performance and Information Management

Robust performance and information management is critical to ensuring the Organisation is able to meet its key objectives, is performing effectively, offers value for money and recognises and manages any risks to delivery. Responsibility for statutory returns and monitoring is managed through these units.

Children's Management Information Unit

The Management Information Unit aims to ensure that we proactively manage, share and exploit data and business intelligence in order to achieve better outcomes for children, young people and their families in Kent.

The Management Information Unit achieves its aims through and by:

- Providing local and strategic information to support the key business needs of Government agencies, FSC, KCC Directorates, Commissioning Partners, Locality Boards and children and families in the community.
- Ensuring that Private, Voluntary and Independent Providers, FSC, KCC Directorates and partner agencies comply with all legislative and statutory requirements to provide and publish information, which in turn informs the centrally allocated funding ratios for the authority.
- Sharing and using the information, providing consultancy, training and other support to effectively inform performance management, strategic planning and service planning, development and design.
- Supporting and informing the management and ongoing development of core SCS business operating systems, including the procurement and implementation of additional systems as agreed with FSC business owners.

Tasks to Support Key Business Needs:

- Providing scrutiny to and for SCS performance.
- Production of data for Directorate and KCC Plans. The Management Information Unit is responsible for the management and review of the performance management and operational performance management frameworks and data quality framework for Specialist Children's Services.
- Data Collection, Submission of Statutory Returns
- To respond to FOI requests and ad hoc request for Management Information within timescale
- Data Quality- identify, manage and resolve data quality errors
- Training and Support- delivery of ICS / Protocols training workshops to systems users

Adults Performance and Information Management Unit

The Performance and Information Management team for Adult Social Care provides regular support and intelligence to staff at all levels of the organisation in order to manage the effective implementation of national and local policy drivers, ensuring that better outcomes are secured for the people of Kent.

The team works very closely with Directors, policy, training and operational staff to embed a performance culture and accountability throughout the organisation by improving data quality, setting targets, understanding and resolving reasons for inconsistent performance and practice, supporting staff with monthly budget and activity monitoring and forecasting, and ensuring that mechanisms are in place for staff to manage their own performance locally and escalate risks.

This requires the team to:

- Focus on developing system reports, particularly operational reports.
- Ensure the system is fit for purpose, and resolve issues with inputting
- Ensure that resolutions are supported by clear operational and system guidance and training, which links with teams and policy.
- Support the implementation of initiatives such as personalisation, health integration with robust performance frameworks, which hold people to account.
- Ensure staff use current performance and activity intelligence to produce budget forecasts locally, which are validated at a county level.

The team is also responsible for National statutory returns, Corporate reporting - both to Cabinet Committee, but also to the Cabinet Member, User surveys, Freedom of Information requests, Identifying and reporting risks to DMT, budget and activity monitoring and analysis, and working with the Department of Health and ADASS to influence the national developments of performance frameworks.
All local performance management feeds into DivMT and DMT reporting, which in turn supports corporate and national returns. This ensures that accountability for performance and the practise behind this, including team feedback, flows through the organisation from front line to Council and National monitoring.

In addition the team will support the development of other national initiatives, including Sector Led improvement, the production of the Local Account, with Service users and carers, as well as supporting ADASS through the ADASS Standards and Performance group.

D: Transformation Programme Team

A small team of two temporary staff support the Transformation Board and the Transformation Stakeholder Board. This team drives forward strategic thinking supporting Managers and staff to engage with the planning and implementation of the Transformation programme.

SECTION B: CONTRIBUTION TO MTP OBJECTIVES

KCC's Medium Term Plan sets out how Social Care Services will shift to a commissioning organisation. This will enable us to deliver social care against growing demographic and financial pressures and within a context of significant national and local change for health and social care. As we reshape our services to focus on commissioning there will be activity throughout 2013/14 to explore ways that will enable older people and people with a physical disability to self manage and put in place preventative and early intervention services to vulnerable children and their families to support them before they reach crisis point.

The Medium Term Plan sets out 3 ambitions which will be supported by the activity of the Strategic Commissioning Division:

1. We will help the Kent economy to grow by:

• Improving how we procure and commission services

Our procurement processes will be open, transparent and proportionate to reduce barriers to entry for Small and Medium Enterprises. We will continue to develop new ways to work with the voluntary and community sector, moving from the provision of direct grants to commissioning more services on a competitive basis. We will also provide training and events to providers to support them in working with us in new ways.

2. We will tackle disadvantage by:

• Improving services for the most vulnerable people in Kent

We will have reduced the number of children in care through new innovative preventative services. We will review our Children's Centres services. There will be improved arrangements with the NHS to secure timely and appropriate treatment or social care support for children and adults requiring mental health services. We will support families with complex needs and increase the use of community budgets

3. We will look to put the citizen more in control through:

• Improving access to public services

Planning for and delivering information, advice and guidance through a range of channels and with the help of service users and carers to identify what their information needs are and how best to deliver them

• Empowering social service users

We will empower service users through methods such as hearing the voice of children and young people in service design, commissioning and assessing and developing the use of personal budgets for disabled children and their families**.** A continuing focus on Enablement Services to provide intensive support so older persons can regain independence as quickly as possible and telehealth and telecare will be assisting older people to live independently in their own homes. A review of domiciliary services will enable us to develop a programme of help at home that meets the needs and wishes of service users and provides more choice about how and when people receive services at home. Building community capacity to prevent social isolation and a slide into dependency will support development of a range of services through the voluntary and community sector providing choice and opportunity to service users in their local area. The Good Day

programme will continue to provide alternative activities to traditional day care services for people with a learning disability.

• **Supporting the transformation of health and social care in Kent**

We will improve patient experience of health and social care by delivering care closer to home and fostering more choice through developing greater diversity of provision from social enterprises and the voluntary and community sector. Strategic Commissioning will work closely with Clinical Commissioning Groups to deliver joint commissioning plans and attend local Health and Wellbeing Boards. There will be a focus on self management, Long term conditions, reablement services and falls prevention.

We will work to jointly commission services for young people with our health partners to ensure we reach the best outcomes for these young people.

• **Ensuring the most robust and effective public protection arrangements**

Ongoing audit and quality reviews give assurance to Members and Senior Managers that safeguarding is robust and effective. The Essex Peer review managed through the SC Adult Safeguarding Unit provided independent confirmation that vulnerable adults in Kent are safeguarded. The Central referral unit is now embedded to help ensure vulnerable adults safeguard referrals are assessed quickly, with swift intervention where necessary

Strategic Commissioning Contribution to Savings and Value for Money:

The draft budget book 2013-14 indicates that:

- **Adult Social Care** must deliver £18.8m savings through Transformation of Adult Social Care with greater emphasis on better procurement, increased prevention and improved partnership with the NHS, through the integration of health and social care commissioning, to deliver better outcomes for Kent residents at lower cost. Health and Social Care Monies will help to redirect funding into community support.
- **Children's Centres**- Saving amount £1.4m from review of support services and central functions relating to running children's centres
- **SEN Transport** Review of provision- SC will contribute to saving 0.8m through re-negotiating contracts
- **Children in Care**- SC will contribute to savings of £5.3m through the commissioning of early help services to prevent children coming into care where it is unsafe to do so and ensuring there are efficiencies made through commissioning individual packages of support and care for children and young people.

SECTION C: PRIORITIES, ACTIONS, PROGRAMMES, PROJECTS, MILESTONES, KEY OR SIGNIFICANT DECISIONS				
Management Teams are required to regularly review progress against the actions and milestones set out in the tables below. Monthly progress may be appropriate for individual services to review their business plan progress, and quarterly may be appropriate at the Divisional level. Formal reporting of progress by Division to Cabinet Committees is required twice a year, at the mid-year point and after the year-end. The Corporate Director is authorised to negotiate, settle the terms of, and enter the following agreements/projects:				
PRIORITY 1: Continue to develop and implement the Transformation Programme to identify new ways of working **(Adult Social Care Priority- Productivity and Financial and Policy Challenges).**		**DESCRIPTION OF PRIORITY:** The transformation programme will deliver FSC's contribution to Bold Steps. It will have numerous workstreams with many key activities. The Transformation Programme is now entering its operational phase and the key activities for 2013-14 are highlighted here. The progress of Transformation is rigorously monitored through Transformation Board, Budget Board and Cabinet Members**.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Organisational Optimisation**	Mark Lobban		
1.1	Agree and implement recommendations from diagnostic phase as a new Transformation workstream	Mark Lobban	January 2012	March 2014
1.2	With efficiency partner identify and quantify efficiencies and benefits of optimisation	Mark Lobban	February 2013	May 2013
2	**Review of Care Pathways**	Mark Lobban/ Head of Programme	**February 2013**	**June 2013**
2.1	Identify ideal pathways for optimum efficient use of all resources, analysis of change required and implementation	Mark Lobban/ Head of Programme	February 2013	June 2013 followed by monthly monitoring
3	**Implementation phase of Transformation - plan and agree phasing of programmes and identify benefits**	Mark Lobban	January 2013	March 2014
3.1	Agree and set up performance framework for agreed activity	Mark Lobban/ Head of Programme	March 2013	May 2013
KEY MILESTONES				DATE (month/year)

A	**Procurement Options Paper for Cabinet**	May 2013
ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 2: Ensure we provide the most robust and effective public protection arrangements.		**DESCRIPTION OF PRIORITY:** Improving quality of practice for adult safeguarding.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1.	**Quality assurance and improving safeguarding practice**			
1.1	Independent audit of safeguarding cases. Ongoing programme of external and internal audits of FSC and KMPT case files, underpinned by effective governance arrangements to report outcomes of audits and safeguarding issues to use audit outcomes to address training and development needs.	Nick Sherlock	October 2011	March 2014
1.2	Develop effective mechanisms to capture feedback from service users and involving the service user/ carer/ family in the safeguarding process	Nick Sherlock	March 2013	November 2013
1.3	Work with Strategy Commissioning to ensure we have in place effective monitoring of providers, particularly around people's safety	Nick Sherlock	March 2013	November 2013
1.4	Develop new initiatives to improve the quality of safeguarding practice. These will be developed from a range of sources, including analysis of safeguarding training, Serious Case Reviews, LGO findings and national reports ,i.e. SCR Winterbourne	Nick Sherlock	March 2013	March 2014
2.	**Effective lead on partnership work in the ongoing implementation of MCA and DoLS across partner agencies**			
2.1	Lead commissioning and ongoing monitoring of new contract for the Kent and Medway IMCA Serve	Annie Ho	March 2013	April 2014
2.2	Effective arrangements in place for KCC taking over DoLS Supervisory Body function from PCTs, including agreement with KMPT regarding Mental Health	Annie Ho	March 2013	April 2014

	Assessors and ongoing review of DoLS governance arrangements			
2.3	Internal MCA Audit	Annie Ho	March 2013	April 2014
3.0	**Effective management of the Kent and Medway Safeguarding Vulnerable Adults Executive Board**			
3.1	Finalise implementation of the governance review, including setting priorities for the next three years in response to the possible new legislation	Barbara Bradley	March 2013	August 2013
3.2	Implement new structure following the governance review, involving establishing new groups and their priorities	Barbara Bradley	March 2013	August 2013

KEY MILESTONES		**DATE**
A	Mechanisms in place to capture post abuse feedback	November 2013
B	Internal MCA Audit Programme established	June 2013
C	New structure of the Kent and Medway Safeguarding Vulnerable Adults Executive Board is implemented	August 2013

ARE THERE ANY SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		**ARE THESE ALREADY IN THE FORWARD PLAN? Yes/ No**
A	**New Deprivation of Liberty agreement with Medway, in light of the Authorisation role now resting solely with Local Authorities**	

PRIORITY 3: Embed New Commissioning structure and improve how we procure and commission services		**DESCRIPTION OF PRIORITY: : Continue to improve processes, develop the market to allow maximum choice, support the local economy and deliver VFM in line with 'Bold Steps', 'The Kent Compact' and 'Spending the Council's Money '**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Manage the market to ensure value for money and to provide choice including for people on direct payments. (ASC priority- Procurement)**	Mark Lobban as part of Transformation	2013	March 2014
1.1	Participate in ADASS programme Developing Care Markets for Quality and Choice DCMQC – support development of Market Position	Mark Lobban, Emma Hanson and Christy Holden	January 2013	January 2014

	Statements MPS to inform future commissioning strategies			
1.2	Engage the care sector market in the transformation programme through a programme of events including provider meetings, co-production workshops.	Emma Hanson/ all Commissioning Managers	January 2013	March 2014 (Review)
1.3	Develop processes that enable small and medium enterprises and voluntary sector organisations to competitively tender to move away from grants onto contracts where appropriate	Emma Hanson/ Samantha Sheppard/ Karen Cook	January 2013	March 2014
2	**Develop commissioning plans for specific service areas e.g. domiciliary care and respite services for people with learning disability to determine if a tendering process is required and then implement (ASC priority- Procurement)**	Heads of Service / Paula Watson (respite)		
2.1	Support to stay at home / Homecare and reablement strategy in place	Emma Hanson/Jo Empson	October 2012	Dec 2013
2.2	Prevention and Wellbeing Strategy produced	Karen Cook	November 12	November 2013
2.3	Production of Accommodation Solutions Strategy	Christy Holden	March 2013	March 2014
2.4	Ensure we have full understanding of equality impact and build equalities into our commissioning processes	Mark Lobban/ HOS/ All staff	January 2013	Review March 2014
3	**Review community based services to ensure best value for money/cost effectiveness and improved outcomes for service users. (ASC priority- Productivity)**	Emma Hanson/Samantha Sheppard	May 2013	September 2013
3.1	Consider delivery of domiciliary care services and future model assessing impact of move to right number of providers through new ways of working- collaboration and federation	Emma Hanson/Jo Empson	January 2013	Dec 2013
3.2	Review of infrastructure organisations and volunteer bureaus to ensure effectiveness and value for money in supporting voluntary sector	Emma Hanson / Samantha Sheppard/ Communities Directorate	January 2013	September 2013

	providers			
3.3	Mapping and analysis of preventative services funded through voluntary sector grants to develop a core offer	Emma Hanson / Samantha Sheppard	January 2013	November 2013
3.4	Review of day care services for older people to ensure a sustainable model for the future	Emma Hanson / Samantha Sheppard	January 2013	September 2013
4	**Develop the workforce to promote effective commissioning across the organisation by organising specific commissioning training (ASC and SCS priority- People)**	Heads of Service		
4.1	Review and rewrite commissioning and contracting processes to ensure effectiveness of the commissioning function tasks to make sure they meet audit and legal requirements in a streamlined manner	Christy Holden/ Emma Hanson/Kate Gifford	February 2013	November 2014
5	**Review and develop new risk assessed approach to quality monitoring**	All Heads of Service/ Steph Abbott/ Nick Sherlock/ Maureen Robinson		
5.1	Commence the Redesign of Quality Monitoring Process - understanding and defining roles and responsibilities how responses will be managed and the approach for all care providers and commissioned services	Christy Holden/Emma Hanson	January 2013	March 2014
5.2	Commence the Redesign of a Quality Monitoring Process for Care in the Home/Community - understanding and defining roles and responsibilities and how responses will be managed. Consider outsourcing in the approach.	Jo Empson and Emma Hanson	January 2013	Dec 2013

KEY MILESTONES		DATE (month/year)
A	Identify service specific areas that will require implementation of a tendering process	April 2013
B	Give notice to Providers where Grants will be ending March 2014	10/13
C	Voluntary Sector conference to co-produce prevention strategy and share effective new ways of working	3/12

D	Working groups in place with support from Procurement to understand and agree new commissioning guidance	April 2013
E	Production of Accommodation Solutions Strategy	Autumn 2013 (review)

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Move to contracts from grant funding where appropriate	No
2	Implementation of tendering process for specific service areas – to be determined and entered onto forward plan when identified	No

PRIORITY 4: Ensure there is a range of vibrant community based services to divert people away from health and social care systems. These services will seek to support a person's lifestyle and engagement with their community (Wellbeing and lifestyle Offer including self funders)		**DESCRIPTION OF PRIORITY:** To deliver a range of health and well-being services designed to promote independence and continue older people's active involvement in their community regardless of age or condition. In particular these services should target vulnerable people who have pre-disposing factors likely to indicate high health needs or likelihood of later care home admission**.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Improve public information to give more people information about independence, choice and control (ASC Priority- Prevention)**	Emma Hanson/ Karen Cook		
1.1	Information, advice and guidance strategy in place	Karen Cook	July 2013	March 2014
1.2	Review of carers information with support from Carers Advisory Group	Karen Cook	March 2013	April 2014
2	**Build community capacity and develop more inclusive access and participation (ASC Priority- Prevention)**	Emma Hanson/ Samantha Sheppard/ Karen Cook		
2.1	**Review of key services and work with Providers to identify ideal core community support offer- i.e. befriending, carers support, social activities**	Samantha Sheppard/ Karen Cook	April 2013	March 2014
3	**Improve access to services for Carers(ASC Priority- Prevention)**	Emma Hanson		
3.1	Develop contract for short term breaks in the home using additional funding form Health Monies to procure more services	Karen Cook/ Steve Lusk	January 2013	Contract let March 2014
3.2	Ensure implementation of carers support and assessment contract which includes new GP Referral services for carers in crisis	Karen Cook/ Steve Lusk	April 2014	Quarterly meetings to 2014
4	**Work through the Kent Learning Disability Partnership Board to improve delivery on key areas for people with disability. (ASC Priority-Partnership)**			
4.1	Support good day programme to ensure inclusive access to community services for people with LD	Paula Watson/ Sylvia Rolfe/Simone Bullen	Ongoing project	March 2014

5	**Further promote personalisation giving people genuine choice and control over their lives. (ASC Priority-People)**		**April 2013**	**March 2014**
5.1	Review and update KCC approach to personalisation up to DH Making it Real programme and deliver action plan against that programme in partnership with Kent residents	Emma Hanson/James Lampert with support from Adult Commissioning Managers	January 2013	March 2014
5.2	Work with KMPT to improve outcomes for service users and promote personalisation **(ASC Priority-Partnership)**	Sue Scammel	January 2013	March 2014
5.3	Taking forward & testing Integrated personal health budgets in SKC CCG as part of DH personal health budget programme	James Lampert/ Jo Empson /Gina Walton	Dec 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Community Prevention and wellbeing conference	March 2013
B	Core Offer for community services planned and agreed	April 2014
C	New carers web based information	May 2013
D	Biannual report to Kent residents progress against personalisation plan	

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Short Term Breaks in the Home Contract	No

PRIORITY 5 : Sustain within the community people who require help and support to meet their health and care needs (help to live at home offer)		**DESCRIPTION OF PRIORITY:** Working towards integrated services that seek to maintain a person within the community and out of residential care or hospital.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Promote enablement and target interventions so that fewer people become dependent on long term care services. (ASC Priority- Prevention)**	Jo Empson, Paula Parker, James Lampert in partnership with CCGs	October 2013	March 2014
1.1	Further develop KEaH and Enablement enhancing efficiencies and effectiveness including ability to flex homecare to support people in a crisis	Jo Empson	January 2013	Review March 2014
1.2	Embed and then review SIS contract to ensure fit; consider within scope of wider Homecare and Reablement Commissioning Strategy	Jo Empson	April 2013	January 2014
2	**Work with the new CCGs to ensure coherent processes and systems across health and social care and to identify opportunities for integrated commissioning and working.** **(ASC Priority-Partnership and Financial and Policy Challenges)**	Supported through Mark Lobban/ Emma Hanson/ James Lampert/ Strategic Commissioning managers	October 2012	March 2014
2.1	Explore with CCGs the opportunity for joint commissioning a patients/service users held shared care record	Mark Lobban/ Emma Hanson/ James Lampert/	Commenced Nov 2012	Sept 2013
2.2	Strategic Commissioning has identified strategic commissioning resources aligned to support development of joint commissioning plans with CCGs, Public Health & District Councils	Jo Empson/Karen Cook/Paula Parker/James Lampert	Commenced Nov 2012	Review Progress September 2013
2.3	Integrate commissioning strategies and plans at CCG level for each area.	Jo Empson/Karen Cook/Paula Parker/James Lampert	October 2012	September 2014
2.4	Actively engage with developing and providing Strategic Commissioning representation at Countywide and Local HWBB	Jo Empson/Karen Cook/Paula Parker/James Lampert	December 2012	March 2014

2.5	Work with CCGs to agree spending plans for Health and Social Care monies, performance manage and review schemes to ensure effectiveness.	Mark Lobban/ Emma Hanson Strategic Commissioning Managers	October 2012	March 2014 (review)
2.6	Work with CCGs, Secondary Care and other partners to develop and implement reablement and new reablement projects aligned with CCG intermediate care reviews	Paula Parker/James Lampert/ Jo Empson	October 2012	By March 2014
3	**Further promote the use of assistive technology and other equipment to enable people to live independently. (ASC Priority- Prevention)**	**James Lampert/Hazel Price**	**Continue Existing programme**	**March 2014**
3.1	Start implementing 3 Million Lives- Kent has Pathfinder Status. Potential 5 year programme	James Lampert/ Hazel Price	November 2013	March 2014 (review)
3.2	Work with 3rd Sector to interface with service users to reach more people and develop understanding of assistive technology and potential for delivery through home care services	All Commissioning Mangers with James Lampert lead	March 2013	March 2014
3.3	Procure and implement range of dementia specific assistive technology to promote positive risk management and promote independence	James Lampert/ Hazel Price	March 2013	March 2014
4	**Work with CCGs , Providers and Public Health to design & implement an integrated, coordinated falls strategy and pathway across Kent**	**James Lampert/ Karen Shaw (PH)**	**Dec 2012**	**March 2014**
4.1	Commission falls response service (in partnership with South East Kent Ambulance Trust)	James Lampert	April 2013	March 2014
4.2	Develop Community Postural stability exercise classes across Kent	James Lampert/ Karen Shaw (PH)/ Hazel Price	April 2013	March 2014
5	**Jointly commission a range of services using NHS South England Dementia challenge funds**	**Emma Hanson**	**Dec 2012**	**Nov 2013**
5.1	Deliver Dementia friendly communities Programme including Dementia Intergenerational Project	Emma Hanson/ Emma Barrett SILK Team	Dec 2012	Nov 2014
5.2	Dementia hospital admission prevention & discharge service	James Lampert	Dec 2012	Nov 2013
5.3	Dementia shared lives project	Emma Hanson/Jane Barnes/Kelly Ann Field	Dec 2012	Nov 2013

6	**Review End of Life Care pathways in partnership with CCGs and in line with Kent's HWB strategy recommendations**	**James Lampert/ Colin Jones**	**Nov 2013**	**March 2014**

KEY MILESTONES		DATE (month/year)
A	Health monies- programmes agreed and started for a 2013 spend	April 2013
B	Deliver projects funded by NHS South of England Dementia Challenge Fund	March 2014

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?	ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	

PRIORITY 6: Take people with identified risk factors who have suffered a critical incident, e.g. fracture and restore them to a state prior to the incident (Rehabilitation offer). Focus on self management and key long term conditions that lead to repeat admissions and lengthy hospital stays, e.g. falls strokes, dementia	**DESCRIPTION OF PRIORITY:** Targeted interventions that aim to restore a person back to a preceding state of health and well-being. Brings together reablement, intermediate care and community health provision post hospital.		
Actions	Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Long Term Conditions (LTC)**		
1.1	Work with CCGs to develop Neuro-Rehabiltation strategy and implement recommendations	Paula Parker/James Lampert/ Jo Empson/ Christy Holden	March 2013	September 2013
1.2	Continue to implement Kent & Medway LTC programme including Risk stratification, integrated health and social care teams and self care strategies	Mark Lobban/ Emma Hanson/ Christy Holden/ All commissioning Managers	Oct 2012	Review progress March 2014
1.3	Pilot Year of Care tariff in partnership with CCGs for people with a Long term Condition	James Lampert/ Janice Grant	Nov 2013	March 2014
2	**Urgent Care**			
2.1	Work with Commissioning Support unit to develop Short term care solutions/Intermediate Care Strategy for Kent	Paula Parker	April 2013	March 2014
2.2	Work with Secondary Care to develop seamless discharge pathways to ongoing short term services	Paula Parker	March 2013	March 2014

2.3	Work with partners to develop an integrated health and social care dashboard	Paula Parker	December 2012	July 2013
2.4	Develop new ways of accessing Information advice and guidance for people admitted to acute and community hospitals working with voluntary organisations	Paula Parker/Karen Cook	July 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Review of Intermediate care paper due to Urgent Care Operational Delivery board 18/12/12	12/12
B	Developing short term care solutions conference (joint health and social care conference to develop what intermediate care/ short term care/ reablement solutions are required to prevent hospital admissions and facilitate hospital discharges)	03/13

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 7: Ensure there is a Strategic Framework for Commissioning for Children and Young People.		**DESCRIPTION OF PRIORITY:** An overview of the strategic priorities for Children's Commissioning. The vision of the unit is to drive, promote and support transformational change through strategic commissioning to ensure the provision of a range of high quality, cost effective, outcome based services for children, young people and their families.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Remodelling services and practice to deliver and demonstrate better outcomes for all children, young people and the wider community within available resources.**			
1.1	Ensure we utilise the voice of young people and their families in shaping service development, commissioning and evaluation.	Helen Jones	April 2013	March 2014
1.2	Review high cost services and the impact of commissioned services for value for money.	Helen Jones	April 2013	November 2013
1.3	Ensure that there is improved integrated commissioning, particularly with ELS and Health, to address gaps in service for vulnerable groups.	Helen Jones	April 2013	March 2014

1.4	Promote use of a diverse VCS to enable partnership working to deliver the best outcomes for children and young people.	Helen Jones	April 2013	March 2014
2	**Improving the commissioning of effective integrated services that enable families to manage and support them in finding additional help when necessary**			
2.1	Develop a resource strategy for shifting resources to early intervention and prevention services.	Helen Jones/Jo Hook	April 2013	July 2013
3	**Staff recruitment and retention, sharing best practice and culture.**			
3.1	Identify professional needs of unit following restructure, promote Kent manager and ensure best practice from KCC and other local authorities in commissioning is shared.	Helen Jones	April 2013	October 2013

PRIORITY 8: Early Intervention and prevention (Children)		**DESCRIPTION OF PRIORITY:** We will ensure there is investment in early help, intervention, and prevention services**(SCS PRIORITY- Prevention)**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Engage and work with families to build their resilience (SCS PRIORITY- Prevention)**			
1.1	Contribution to the Kent Troubled Families Programme and the Kent Integrated Adolescent Support Service work being led by colleagues in Customer & Communities, and Education Learning & Skills. **(SCS PRIORITY- Prevention)**	Jo Hook	April 2013	March 2014
2	**Commission Integrated Services for better value**			
2.1	Review commissioned Early Intervention services to ensure they supply an effective provision which is cost effective and improves outcomes.	Jo Hook	April 2013	October 2013
2.2	Develop payment of results methodology for early intervention services	Jo Hook	April 2013	October 2013
2.3	Support the integration of commissioned services with	Jo Hook	April 2013	March 2014

	in-house services as part of Kent's early intervention and prevention strategy			
KEY MILESTONES				DATE (month/year)
A	Contracts start for young carers, parenting, FIP and family mediation			April 2013
B	Performance management framework for commissioned services in place			April 2013
C	Monitoring of all EIP commissioned services undertaken and evidence of improved outcomes and value for money.			March 2013 (Quarterly review)
D	EIP strategy reviewed and updated where appropriate.			September 2013
ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?			ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No	

PRIORITY 9: Disabled Children		**DESCRIPTION OF PRIORITY:** Ensure KCC responds effectively to the needs of children and young people with SEN and disability in Kent.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Engage health and wellbeing board to ensure health reforms respond effectively to the needs of children with SEN and disability. (SCS PRIORITY- Partnerships)**			
1.1	Work with colleagues in public health to jointly commission services where appropriate. **(SCS PRIORITY- Procurement)**	Liz Williams	April 2013	March 2014
1.2	Work with colleagues in NHS Kent and Medway to jointly fund and commission overnight short breaks services as appropriate under the NHS Act 2006, Section 75 Agreements.	Liz Williams	April 2013	May 2013
2	**Implement direct payments where possible**			
2.1	Look at the possibility of jointly commissioning a direct payment system with the adults' services, to enable young people and their families to have choice	Liz Williams	January 2013	September 2013

	in which services they access.			
2.2	Ensure that support services are available to families to enable them to manage a direct payment	Liz Williams	April 2013	March 2014
2.3	Implement access to the Kent Card	Liz Williams	April 2013	November 2013
3	**Ensure that short breaks services are available to comply with statutory requirements**			
3.1	Involve children and young people and their families in shaping service development, commissioning and evaluation. (SCS PRIORITY- People).	Liz Williams	April 2013	October 2013
3.2	Require providers to engage with children, young people and their families in the planning and development of every short break and family advice and support service commissioned	Liz Williams	April 2013	March 2014
4	**SEND Pathfinder programme**			
4.1	Support SEND Pathfinder Programme including development of a Local Offer; integrated Health, Education and Social Care Plan and Personal Budgets	Liz Williams	April 2013	September 2014

KEY MILESTONES		DATE (month/year)
A	Commissioning of a Disabled Children's Family Advice and Support Service	Feb 2013-Sept 2013
B	Contracts called off and awarded through the Disabled Children's Short Breaks Framework	October 2013
C	Grant awarded through the Disabled Children's Community Chest Grant Process	Jan 2013-March 2013
D	Monitoring of all disabled children services	Quarterly

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Implementation of direct payments for young people.	October 2013
2	Implementation of specifically targeted specialist services	N
3	Implementation of personal budgets with ELS and Health	N

PRIORITY 10: Children's Centres		**DESCRIPTION OF PRIORITY:** Review and reform of children's centre provision as part of KCC's Future Service Options programme. **(SCS Priority- Productivity)**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Children's Centres Service Transformation (SCS Priority - Productivity)**			
1.1	Develop public consultation document (as required) based on Make, Buy, Sell Steps 1 – 3, local and strategic engagement, analysis and impact assessment of options and local solutions.	Karen Mills	April 2013	May 2013
1.2	Public Consultation exercise	Karen Mills	May 2013	August 2013
1.3	Report outcome of Consultation to inform decision making	Karen Mills	October 2013	October 2013
1.4	Support implementation of 'decision'.	Karen Mills	November 2013	March 2014
2	**Support the commissioning of Children's Centre services (and commissioned centres) in line with the Core Offer and EIP Strategy**			
2.1	Support the delivery of proposals to achieve the 2013/14 Children's Centre programme efficiency savings.	Karen Mills	April 2013	March 2014
2.2	Maintain a register for all services and support local commissioning and performance management of commissioned Children's Centre services (currently 106), commissioned centres (currently 8) and nursery provision (currently 49) to enable accurate and timely reporting, facilitate improvements to the commissioning process and ensure that services comply consistently with procurement regulations.	Karen Mills	April 2013	March 2014
2.3	Promote vibrant and diverse VCS (SCS Priority-Procurement) – identify and remove the barriers faced by the VCS in commissioning services in Children's centres.	Karen Mills	April 2013	March 2014

3	**Support operational arrangements (transition)**	Karen Mills	April 2013	March 2014
3.1	Strengthen and support delivery of the Children's Centre programme through 12 identified work streams. Ensuring all statutory requirements and local priorities are met.	Karen Mills	April 2013	March 2014
3.2	Support Children's Centres to maintain and improve existing level of achievement in Ofsted inspections.	Karen Mills	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Impact of additional potential reductions to Early Intervention Grant identified	April 2013
B	Agreement of Public Consultation	May 2013
C	Decision on recommendations made	October 2013
D	Assess the implications of the revised Ofsted Inspection Framework with necessary recommendation for actions	Spring 2013
E	Assess the impact of the revised DfE statutory guidance with necessary recommendations for actions	Expected Autumn 2012 (delayed)

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1	Decision on Children's Centre Service Transformation	October 2013

PRIORITY 11: Health and wellbeing (Children)		**DESCRIPTION OF PRIORITY:** Delivery of services that promote good health and wellbeing for young people in Kent to ensure positive outcomes for these children. **(SCS Priority- Productivity)**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Jointly commission with health to address gaps in services for vulnerable groups (SCS Priority- Procurement)**			
1.1	Contributing to the public health preventative and tackling inequalities agenda **(SCS Priority- Prevention)**	Sue Mullin	April 2013	February 2014
1.2	Aim to secure funding from 7 CCGs to enable rollout of post abuse services across the county.	Sue Mullin	April 2013	April 2013
2	**Develop framework of approved therapists**			
2.1	Work to develop a framework of approved therapists to be used for future procurement exercises.	Sue Mullin	April 2013	March 2014
3	**Delivery of highest quality and responsive practice to improve outcomes for children and young people. (SCS Priority- Productivity)**			
3.1	Ensure CiC element of the CAMHS service is embedded and demonstrating improved performance.	Sue Mullin	April 2013	October 2013
4	**Implement contract variation to the leaving and after care service (Catch 22).**			
4.1	Put in place robust performance management and budget monitoring framework.	Sue Mullin	April 2013	Quarterly through 2013/14
4.2	Support Director of SCS to review leaving and after care services and develop forward strategy	Sue Mullin	April 2013	September 2013

KEY MILESTONES		DATE (month/year)
A	Framework developed of approved therapists.	March 2014
B	Reviewing CiC element of CAMHS service to ensure improvement is being made.	Quarterly

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 12: Children Living Away From Home (SCS Priority- Procurement)		**DESCRIPTION OF PRIORITY:** Review and manage contracts for services for children living away from home to ensure these young people are getting the best service possible, for good value		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Review high cost services within children living away from home category. (SCS Priority- Procurement)**			
1.1	Continue to negotiate residential placement costs through Placement Support Services	Michelle Hall	April 2013	May 2013
1.2	Implement the new Access to Resources Team.	Helen Jones	April 2013	May 2013
1.3	Implementation of an independent fostering framework agreement	Michelle Hall	April 2013	April 2013
1.4	Work with strategic procurement regarding options for residential children's homes, accommodation, and support accommodation for unaccompanied asylum seeking children.	Michelle Hall	April 2013	August 2013
1.5	Review SCS Client Transport to make savings towards the Medium Term Financial Plan	Michelle Hall	April 2013	March 2014
2	**Manage the newly developed contracts register**			
2.1	Oversee the procurement of contracts across all children's services. **(SCS Priority- Procurement)**	Michelle Hall	April 2013	March 2014
2.2	Overview the monitoring of progress of contracts across the service.	Michelle Hall, Sue Mullin, Liz Williams, Jo Hook, Karen Mills.	April 2013	March 2014

KEY MILESTONES		DATE (month/year)
A	Access to Resources Team in place.	May 2013
B	Independent Fostering Agreement in place.	April 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 13: Continuously review performance information and scrutiny to support and improve operational business and outcomes for service users. CHILDRENS.		**DESCRIPTION OF PRIORITY:** To review and implement robust management information systems to support scrutiny and performance management, service delivery, data collection and reporting requirements		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Improve the availability of information sets, integrating data from multiple sources to provide a 'richer picture' of service delivery to the children and young people of Kent**			
1.1	Provide a comprehensive suite of Performance Monitoring Reports for use by KCC, its partners and regulators.	Maureen Robinson	April 2013	March 2014
1.2	Improve transparency and access to SCS Performance Monitoring information through increased use of the KNET SCS Performance Management site.	Maureen Robinson	April 2013	March 2014
1.3	Integrate CAF Reporting into SCS Performance Reporting	Maureen Robinson	June 2013	September 2013
1.4	Implement Activity and Performance Reporting for Children's Centres	Maureen Robinson	January 2013	April 2013
1.5	Ensure the availability of Equality and Diversity information within scheduled performance reports for SCS.	Maureen Robinson	April 2013	June 2013
2	**Support the development and implementation of the Liquid Logic PROTOCOL system, ensuring that information required for operational business and service delivery can be recorded and reported upon appropriately.**	**Maureen Robinson**		
2.1	Specify, develop and test a suite of reports to ensure that Case Management/tracking, Performance Monitoring and Data Quality are all effectively supported.	Maureen Robinson/Ian Valentine	April 2013	March 2014
2.2	Identify and rectify data migration errors to ensure accurate data is held against children's electronic records.	Maureen Robinson	April 2013	September 2013

2.3	Provide appropriate levels of PROTOCOL training to ensure that system users are competent in its use.	Maureen Robinson/Darren Laurie	April 2013	March 2014
2.4	Review Data Quality Plan for SCS for use with PROTOCOL to ensure that data recorded is accurate, timely, relevant, reliable, valid and complete and complies with guidance in KCC's Data Quality Policy.	Maureen Robinson	June 2013	September 2013
3	**Implement robust systems for children' social care statutory reporting**	**Maureen Robinson**		
3.1	Submission of all Children's Social Care Statutory Returns within timescale, ensuring that full data quality checks have been completed by MIU, validation checks are undertaken by the relevant business unit, and that information contained within the Return is signed off appropriately prior to submission to the DfE.	Maureen Robinson/Ian Valentine	April 2013	June 2013
3.2	Implement changes in recording/reporting requirements as directed by the DfE.	Maureen Robinson	April 2013	April 2013

KEY MILESTONES		DATE (month/year)
A	Review of all SCS Performance Reports	April 2013
B	Implementation on Children's Centre Activity and Performance Reporting	April 2013
C	Submission of Statutory Returns for Children's Social Care	May/June 2013
D	Implementation of PROTOCOL	May 2013

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		

PRIORITY 14: Support the delivery of FSC key business objectives with timely, relevant, effective information management. ADULTS	DESCRIPTION OF PRIORITY: The Performance and Information Management team will develop and provide services that support delivery of key business objectives- to support transformation programme and ensure adequate recording and scrutiny of safeguarding data across the Directorate.

ACTIONS		Accountable Officer	Start Date (month/year)	End Date (month/year)
	ADULTS			
1	**Work with DivMT's to develop an outcome based performance framework to evidence the progress of the transformation programme, ensuring that the systems meet our requirements**	**Steph Abbott**	February 2012	March 2014
2	**Further embed the personalisation culture and ensure that staff are fully aware of the concept of a personal budget and how it is recorded (ASC Priority- People)**	**Steph Abbott**		
2.1	Ensure that training and support is provided for those teams that are identified as needing more support.		October 2012	March 2014
3	**Ensure staff understand the process for inputting safeguarding data.**	**Steph Abbott**		
3.1	Support staff with training and 1:1 support where inputting or process issues are not understood		October 2012	March 2014
3.2	Ensure that admin support for the teams is assessed as competent.		October 2012	March 2014
4.0	Ensure Kent is linked into the development and implementation of new National statutory returns, initiatives relating to Sector Led Improvement and ADASS support.	Steph Abbott	Existing programme of work	March 2014

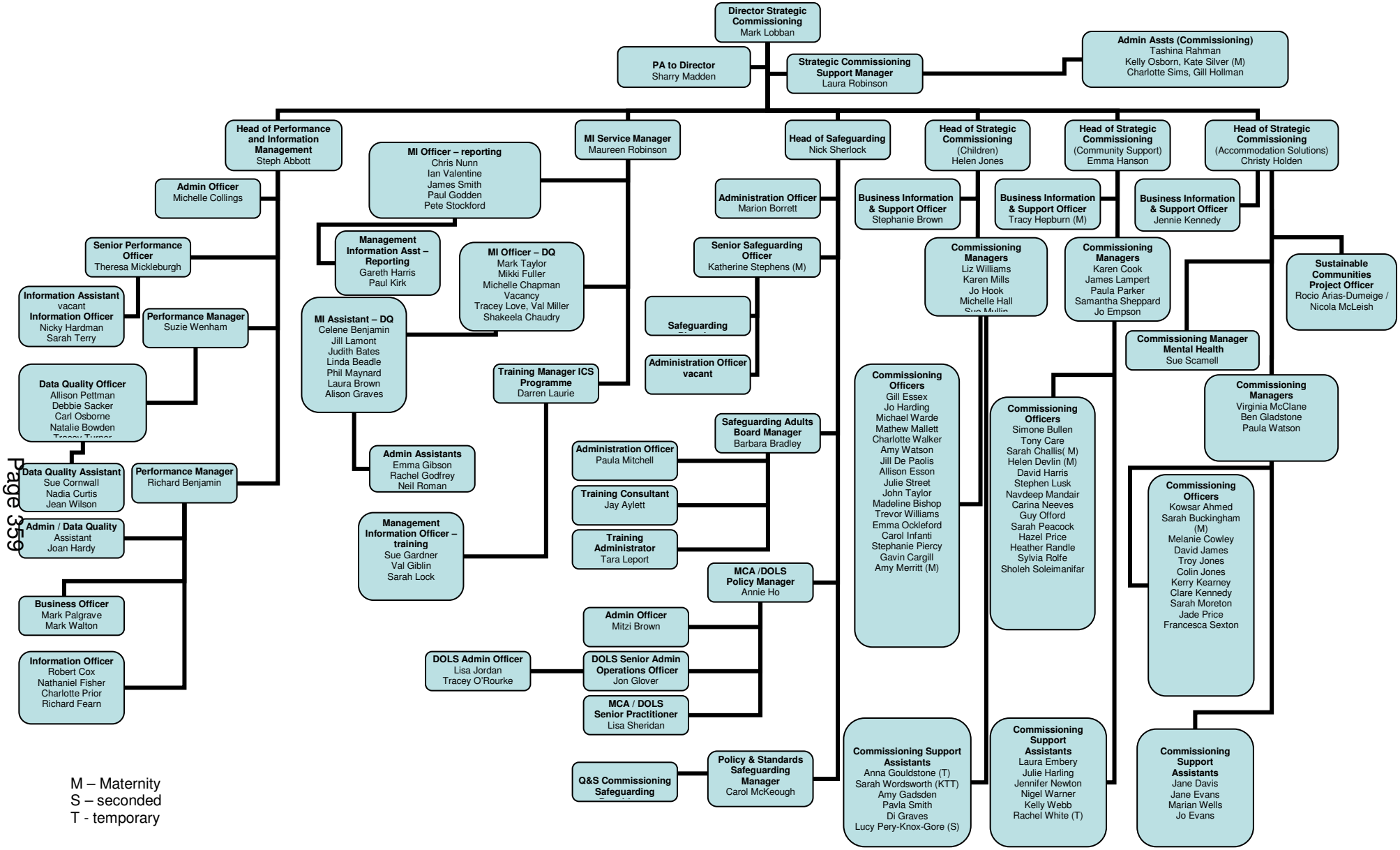
KEY MILESTONES		DATE (month/year)
A	Development of an integrated performance framework	March 2013
B	70% eligible people are in receipt of a personal budget by March 2013	March 2013
C	All cases are allocated a lead officer	Quarterly
D	All cases are closed in a timely and accurate way	Quarterly
E	A local Account is produced with service users and carers	March 2014

SECTION D: FINANCIAL AND HUMAN RESOURCES

For the Financial Resources section **Finance** will provide the required information and detail that sets out the main components of your budget by completing the table below.

FINANCIAL RESOURCES								
Divisional Unit	**Responsible Manager**	**Staffing**	**Non Staffing**	**Gross Expenditure**	**Service Income**	**Net Expenditure**	**Govt. Grants**	**Net Cost**
		£	**£**	**£**	**£**	**£**	**£**	**£**

HUMAN RESOURCES		
FTE establishment at 31 March 2013	**Estimate of FTE establishment at 31 March 2014**	**Reasons for any variance**
177	180	Phase 2 of the Access to Resources Children's Team – expected September 2013



M – Maternity
S – seconded
T - temporary

SECTION E: RISK & BUSINESS CONTINUITY

RISKS	MITIGATION
The Transformation programme is likely to have a significant impact on the Directorate and social care services. In Children's Services the Improvement Plan and need to transform social care will have an impact on Strategic Commissioning.	• Regular Reporting arrangements to Senior Managers and Members. Transformation Blueprint. • Support of consultants to make sure we do the right things at the right time • Children-Improvement Board in place
Safeguarding The Council must fulfil its statutory obligations to effectively safeguard vulnerable adults	• A range of governance and reporting arrangements to Senior Mangers and Members and regular quality assurance reviews • Safeguarding Board- • Multi-Agency Public Protection Arrangements • Quarterly reporting to directors and Cabinet Members. • Complaints process/advocacy. • Mental Capacity Act Arrangements • Positive Risk Management Policy • Implementing of safeguarding stream for independence in place • Extensive staff training • Multi agency Central Referral Unit established. • On-going programme of external and internal audits including peer review. • Action plan based on recommendations of the Peer Review is in place
Implementation of new structure within Strategic Commissioning Ability to manage business process with fewer staff through the recruitment stage of the restructure. A number of key posts are vacant that require some of the fundamental roles to be undertaken (payments to care homes/day care providers/domiciliary agencies) and processes lacking structure and support due to individuals moving on from the unit (Individual Contracts, LD Cost Matrix, PD Cost Matrix). Implementation of SIS. Quality Monitoring providers and links to Safeguarding	• Regular monitoring of outstanding work • Use of overtime in exceptional cases to individuals in the unit and those that have moved on to new units that have the skills • Appointment of a temporary admin staff member to underpin some work to free up staff to process • Planned short term project to manage split of functions
Growing Demand and Financial Pressures	• Review and re-focusing of early intervention and prevention

	services for children and young people • Continuing to improve signposting, information, advice and guidance • Transformation and reshaping of services for adults to encourage self management wherever possible and for children to make best use of resources- such as through children's centres • Continuing to move to personalised services and direct payments • Maintaining preventative services to help people stay independent for as long as possible • Implement Children's access to resources team
Organisational Change and restructure Centralisation of some support services e.g. finance, personnel, training, information systems and some policy. This could lead to less specialist support to FSC managers and breakdown in processes resulting in late payments to Providers	Close working with Finance and other teams to ensure managers are aware of any risks**.**

BUISNESS CONTINUITY
The Division has up-to-date Business Continuity Plans in order to provide essential services when faced with a business disruption. Each department has undertaken a Business Impact Analysis and produced a Business Continuity Plan. In addition, business continuity planning forms part of the contracting arrangements with our private and voluntary sector providers. Our plans provide assurance that effective risk and business continuity management is being undertaken for each service, and that there is a clear synergy between the business plan, service risk register, and business continuity plan. Business Impact Analysis is reviewed at least every 12 months, or when substantive changes in processes and priorities are identified. The availability of up-to-date plans will ensure that the Directorate can continue to operate and provide essential services, at least, to a pre-determined minimum level, in the event of a major business disruption. The table below headlines the Division's most critical processes and the minimum level of service at which the function will be delivered following a significant business disruption. Further details regarding critical functions and their supporting resources are detailed in the Directorate's Business Impact Analysis.

CRITICAL FUNCTIONS	TIMESCALE	MINIMUM SERVICE LEVEL
Local Access Response	4 hours	Maintain critical access for internal and multi-agency partners to adult and children's social care commissioned services, providing advice and support on the availability and use of contracts. Maintain a duty service for staff, public and multi-agency partners to Adult Safeguarding Unit to provide information, advice and guidance on safeguarding issues including Mental Capacity Act Deprivation of Liberty processes.
Emergency and Business Critical Management Reporting	4 hours	Provide critical business reports and access to information including emergency reports, statutory returns, finance information, risk management, service performance, safeguarding reporting and identifying vulnerable people in a major emergency. Ensure input of statutory data on behalf of SCS such as Persons who pose a risk and OLA LAC.
Deprivation of Liberty (Mental Capacity Act) Process	4 hours	Maintain response to applications from social and health care providers across Kent and Medway for Deprivation of Liberty authorisation, instructing assessors and issuing outcomes within the statutory time frame on behalf of local authority and health partners.
Procurement Process	24 hours	Procure individual placements and priority services on behalf of service units, service users, providers and key stakeholders. Co-ordinate provision across social care providers to ensure individual client need is met.
Business Information Management	3 days	To maintain critical business information (records contractual, financial, other information assets) and all aspects of record keeping, including hardcopy and electronic data formats (Swift, ICS, Contracts database), in line with Information Governance procedures.
Contract Management and Performance Monitoring	3 days	Monitor provider performance; manage issues, incidents (including supporting safeguarding process), priority contract reviews, variations and other changes. Manage priority tenders and evaluation and letting of contracts.
Commissioning and Decommissioning of services (including joint commissioning with Health)	3 days	Maintain commissioning and decommissioning activity of adult and children's social care services in partnership with service units, service users, providers and key stakeholders. (Assess equality impact, identify risks and need, plan, specify service, evaluate tenders, award contract, manage transition arrangements, market and service development, provider relationship management).

Support sustainability and climate change ISO14001
Build into our contracting arrangements with external social care providers the requirements to have business continuity plans in place
Support the drive to build into our contracting arrangements environmental sustainability and take advantage of commissioning and supply chain opportunities to limit environmental impact

SECTION F: PERFORMANCE AND ACTIVITY INDICATORS

The work of the Strategic Commissioning Unit will impact on a number of key indicators providing assurance for quality of data, monitoring, and scrutiny of performance. However the Division is not directly responsible for the delivery of any Performance Indicators. Performance Indicators we support include:

Percentage of children adopted
Percentage of social care clients who are satisfied that desired outcomes have been achieved at their first review
Number of adult social care clients provided with an enablement service
Safeguarding Alerts Adults - number and type of abuse
70% eligible people are in receipt of a personal budget by March 2013
All cases are allocated a lead officer
All cases are closed in a timely and accurate way
Percentage children in care in fostering placements
Percentage children in care in fostering placements
Percentage of SCS cases closed that have been stepped down to CAF/ Preventative Services
Number of disabled children whose families receive Direct Payments

SECTION G: ACTIVITY REQUIRING SUPPORT FROM OTHER DIVISIONS/SERVICES (For example Property, ICT, Business Strategy, Human Resources, Finance & Procurement, Planning & Environment, Public Health, Service Improvement, Commercial Services, Governance & Law, Customer Relationships, Communications & Community Engagement or other Divisions/Services)		
ACTIVITY DETAILS	EXPECTED IMPACT	EXPECTED DATE
All Commissioning activity	Procurement, Finance, Legal advice and guidance including Procurement Board, Communications and Community Engagement	Ongoing through 2013-14
Commissioning protocols and guidance	Procurement	September 2013
Ending Grant funding	Finance support with budgets Legal	End March 2014
CVS Infra structure review	Communities support and advice re impact on volunteering policy	To September 2013
Commissioning training offer	Learning and Development	Summer 2013
Prevention strategy	Business Strategy advice and guidance on National position and effective interventions	September 2013
Dementia Friendly Communities project	Communities SILK team	2013-14
Understanding our Communities and needs analysis.	Demographic profiles, use of Mosaic, Health data… from both Public Health Observatory and Business Strategy Research and intelligence units	Ongoing to deliver Prevention strategy, domiciliary plan, long term conditions plan.
Troubled Families Agenda and the Kent Integrated Adolescent Support Service	Work collaboratively with Customer and Communities, and Education Learning and Skills on these agendas.	Ongoing through 2013-2015
Falls strategy	Joint work with Public Health developing capacity and rapid response	Throughout 2014

By: Graham, Gibbens, Cabinet Member for Adult Social Care and Public Health.

Meradin Peachey - Director of Public Health

To: Social Care and Public Health Cabinet Committee – 11 January 2013

Subject: Business Planning 2013/14 – Draft Plans

Classification: Unrestricted

Purpose: Following the development of the business planning headline priorities in November 2012, Directors and Heads of Service have built on the feedback received from Cabinet Committees to develop substantive draft business plans for 2013/14.

This year the emphasis has been on reducing the burden of business planning with a lighter touch process, whilst increasing the consistency and synergy between business planning, and both the performance management dashboards and divisional risk registers that underpin the business plan actions.

The Social Care and Public Health Cabinet Committee is asked to CONSIDER and COMMENT on the draft Public Health Business plan, ahead of the Cabinet key decision to approve business plans in March 2013.

1. Background

1.1 A pre-requisite to delivering key organisational priorities, both in the medium and long-term, is an effective business plan. Offering a clear focus on the delivery of agreed strategic outcomes through day-to-day activity.

1.2 During the November cycle of Cabinet Committees meetings, each Committee was given the opportunity to discuss and comment on the high-level 'headline priorities' for each division. This feedback was considered and reflected as early substantive draft plans were developed, to ensure that the headlines evolved into more detailed activity, with known legislative, policy and financial constraints taken into account.

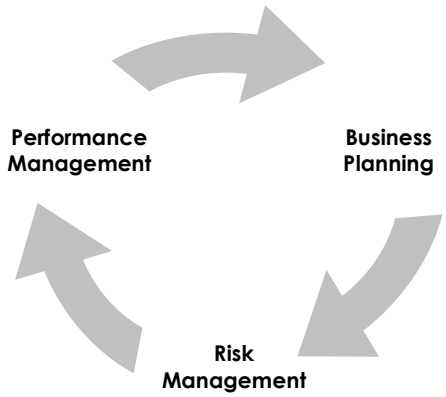
1.3 The emphasis for the 2013/14 draft business plans is identifying clear, tangible actions, ensuring that all activity is Specific, Measurable, Attainable, Realistic and Time bound (SMART). Actions are underpinned by milestones to check activity progress and further complemented by meaningful Key Performance Indicators (KPIs) and Activity Indicators that enable the organisation to monitor and manage performance, to demonstrate progress against the delivery of Bold Steps for Kent. High level risks relating to the delivery of the actions are set out in the

business plan, supported by detailed Divisional and Directorate Risk Registers.

1.4 The draft plans are still at an early stage of development, with further refinement over the coming months before approval in March 2013. The Policy and Strategic Relationships team has been supporting Directors and Directorate Management Teams (DMT) to develop their draft plans as part of ongoing, informal Quality Assurance process, to help embed the revised business planning process.

2. Business Planning, Performance Management and Risk

2.1 It is important that the business planning process closely complements and supports the work already underway to improve the quality and consistency of performance and risk management across the organisation. As such, to help reduce the burden of business planning development on the directorates, the draft business plans draw on the existing work to prepare the Directorate Performance Dashboard and Divisional Risk Registers. This helps to reduce the duplication of effort, and enhances the relationship and synergies between planning, risk and performance. This will enable business planning to become a meaningful tool to influence day to day business whilst ensuring that KCC's strategic priorities are met. Cabinet Committees play an important role in providing oversight and assurance of these synergies through the bi-annual business plan outturn monitoring process.



2.2 **Performance Management**

All business plans actions are measured against a selection of focused key performance and activity indicators. Keeping all actions SMART will ensure that meaningful management information is developed to support the Performance Dashboards reported to Cabinet Committees on a quarterly basis.

2.3 This year, divisions have taken feedback from Cabinet Committees on Performance Management Dashboards into account when developing their 2013/14 performance measures. The focus has been on being more focused in only selecting KPIs that are the most meaningful and accurate reflection of progress against key priorities. This will allow more concise reporting of performance to Cabinet Committees in the coming year's dashboard.

2.4 **Risk Management**

Key risks and mitigating actions faced by Public Health in its 2013/14 business plans are outlined in Section E of the plan. As part of the transition planning, work has been planned to develop and consolidate a specific risk register for Public Health and to ensure this is incorporated into the KCC wide Corporate Risk Register.

3. Business Planning Timetable 2013/14

3.1 Historically, business plans were approved by Cabinet and then potentially called into scrutiny. From 2013/14 business plans will be made as an annual Key Decision, with Cabinet Committees playing a key role in considering and shaping the draft plans prior to approval as part of pre-scrutiny.

3.2 As a result the timetable for the development of business plans has been brought forward so Committees have an earlier opportunity to comment on draft plans. As such, this will be the last opportunity for Cabinet Committees to formally consider draft plans before approval by Cabinet in March 2013.

3.3 The Social Care and Public Health Cabinet Committee is asked to CONSIDER and COMMENT on the draft business plans for Public Health, set out in **Appendix B**.

3.4 It is important to note that at this early stage the draft plans are not intended to capture all of the planned activity for the forthcoming year. In addition to this, it is not possible to include detailed financial information, as the 2013/14 budget has not yet been allocated by th e Department of Health. As such, the plans have some incomplete sections and will require further development and refinement.

3.5 Following feedback from the Cabinet Committee, the responsible Corporate Directors, Directors and Cabinet Members will further develop and refine the draft plans.

3.6 In February, the plans will be submitted to the Policy and Strategic Relationships team for formal quality assurance, which will focus on ensuring the consistency between plans, in particular cross-cutting links to support transformation programmes and organisational priorities. A

letter outlining the quality assurance feedback will be sent to Directors to allow a further opportunity to reflect this before the approval and submission of the final business plans to Cabinet for key decision in March 2013. The approved plans will go live and be published online in April 2013.

4. An Iterative Process

4.1 The 2013/14 business plans are the starting point for future development and will be refined and improved each year as part of an iterative annual process. As the plans progress through 2013/14 the synergy between performance, risk and business planning will be emphasised. In turn this will make the 2014/15 business planning easier as processes and reporting are embedded and become more consistent and complementary.

4.2 The new Section G in the plan will help to establish a clear recognition of how different service divisions link with corporate support services to achieve shared objectives across the business. The aim of this is to help effectively plan and manage capacity with limited resources, as well as enabling associations to be identified across the business plans, particularly identifying complementary and conflicting activity, to reduce the limitations of working in silos.

4.3 The findings from the quality assurance and auditing of the business planning process for 2013/14 will be taken into account to update the process for 2014/15. This will include updating any documentation and refreshing the supporting management guide to further aid the effective development of business plans in the future.

5. Recommendations

The Social Care and Public Health Cabinet Committee is asked to:
CONSIDER and COMMENT on the draft business plans set out in Appendix B.

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Background Documents: *None*

Divisional Business Plan 2013-14

Directorate Name: Business Strategy and Support
Division/Business Unit Name: Public Health

EXECUTIVE SUMMARY:
Cabinet Portfolio: Graham Gibbens – Cabinet Member for Adult Social Care and Public Health
Responsible Corporate Director: Andrew Ireland
Responsible Director: Meradin Peachey
Head(s) of Service:
Gross Expenditure: tbc
FTE: tbc

SECTION A: ROLE/PURPOSE OF FUNCTION

The Health and Social Care Act 2012 will mean that from 1 April 2013 KCC will assume new responsibilities for key elements of Public Health. This includes the statutory responsibilities for:

- Improving the health of the Kent population
- Protecting the health of the Kent population
- The delivery of certain mandated Public Health services (listed below)

These new responsibilities and the related transfer of resources from the NHS dramatically change the way that the County Council will be tackling public health and health inequalities. It will, however, build on the progress made to date with the existing KCC Public Health team and the experience of the Director of Public Health as a joint KCC/NHS appointment.

Future work of the function will be driven by a key number of drivers

- Bold Steps for Kent
- The Kent Health Inequalities Action Plan – "Closing the Gap"
- The Health and Wellbeing Strategy
- The (national) Public Health Outcomes Framework
- Statutory mandated Public Health responsibilities
- The Annual (statutory) Public Health report

The Business Plan for 2013/14 is in effect a transition business plan, partly because certain services and programmes will be transferred as they currently exist, partly because changes to some of these programmes already agreed by the Social Care and Public Health Cabinet Committee in 2012/13 will start to emerge.

The KCC Public Health Unit's main objective is to provide the leadership and strategic framework to enable effective action to be implemented to address the public health priorities identified in Kent. These priorities include reducing health inequalities, improving children's mental health and wellbeing; improving sexual health and reducing teenage conceptions, increasing the number of adults living healthier lives; enabling more people with chronic disease to live at home; reducing the harms caused by substance misuse and/or excessive alcohol drinking.

The function will be responsible for some 23 service areas of which the following are mandated

- Appropriate access to sexual health services
- Steps to taken to protect the health of the population
- Ensuring NHS Commissioners receive the public health advice they need
- NHS Health checks

- National Child Measurement Programme

Public Health programmes are outsourced and commissioned through a variety of providers. The biggest programmes in terms of budgets are sexual health, drugs and alcohol, health checks, tobacco control and smoking cessation services, healthy weight and schools based services such as school nurses and the National Childhood measurement programme.

Substance and Alcohol Misuse services are already commissioned services in KCC through KDAAT, and there is an established team delivering these via corporate plan in Customer and Community Directorate. The public health priority is to ensure that preventative services are equitable, delivering to outcomes and aligned to CCGs and districts needs.

The Health Intelligence and Operational Research function is responsible for providing the evidence base for public health interventions and health service commissioning. It is also responsible for producing two statutory documents; the Annual Public Health Report (APHR) and the Joint Strategic Needs Assessment (JSNA). The JSNA is statutory responsibility of the Health and Well-being board. The JSNA also informs the Health and Well-Being Strategy.

Key Priorities for 2013/14 include

- Creating and sustaining the new partnerships required in the newly reconfigured NHS
- Actively contributing to the integration of health and social care
- Developing and implementing a forward programme of service redesign
- Sustaining and improving performance whilst managing change
- Moving to an outcomes based framework (outcomes, not targets) and more payment by results contracts
- Delivering the appropriate objectives of the Health and Wellbeing Strategy and the Health Inequalities Action Plan
- Further developing appropriate community-based/ community-led interventions (e.g. HOUSE Connecting Communities)
- Development of the market for opportunities for new providers
- Developing and emphasising our approach to improving the patient experience and quality of health improvement/protection services
- Publication of the JNSA
- Publication of the APHR
- Development of both County and substructure CCG based Health and Wellbeing Boards

SECTION B: CONTRIBUTION TO MTP OBJECTIVES

A. Overview

The work of the Public Health Division contributes to the achievement of the MTP Objectives of Bold Steps

- We will help **the Kent economy to grow** by directing our revenue resources towards helping businesses in difficult times, procuring more of our goods and services from within the county wherever possible, encouraging growth and diversification of the market by supporting voluntary sector and encouraging social enterprise.
- We will look **to put citizens in control** through the increasing localisation of services so that local communities can decide their priorities within the resource available. We will work through local arrangements, Joint Commissioning Groups and Health and Wellbeing boards to ensure we are engaged with local agendas and understand and address local priorities.
- We will help **to tackle disadvantage** by making the best use of resources available to target populations with poorer health outcomes – particularly for those in areas of deprivation or for vulnerable individuals who find it more difficult to access services. We will deliver **Kent's Health Inequalities** action plan and support Districts and other partners to develop their own action plan addressing their geographical area or specific key functions- such as Housing.

B. KEY ACTIVITY FOR PUBLIC HEALTH TO SUPPORT DELIVERY OF MTP:

More particularly Kent Public Health will directly contribute to

Bold Steps Priority 1: Improve how we procure and commission services

Public Health will be commissioning several millions of pounds of services and as part of the service transformation planned we will look to develop the provider base including the voluntary and community sectors. We will review how we contract and with whom and develop and implement a rolling programme of change, moving to an outcome focussed system and payment by results.

Might want more here

Bold Steps Priority 2: Support the transformation of health and social care in Kent.

The publication of the JSNA supports all three ambitions of Bold Steps for Kent. Specifically Ambition 2.

We will focus on reducing health inequalities by focusing on those communities with the poorest health outcomes. Services will be improved through offering greater choice and where possible community based settings.

Might want more here

SECTION C: PRIORITIES, ACTIONS, PROGRAMMES, PROJECTS, MILESTONES, KEY OR SIGNIFICANT DECISIONS

Management Teams are required to regularly review progress against the actions and milestones set out in the tables below. Monthly progress may be appropriate for individual services to review their business plan progress, and quarterly may be appropriate at the Divisional level. Formal reporting of progress by Division to Cabinet Committees is required twice a year, at the mid-year point and after the year-end.

The Corporate Director is authorised to negotiate, settle the terms of, and enter the following agreements/projects:

PRIORITY 1: Health Improvement Adults	**DESCRIPTION OF PRIORITY: Health improvement is concerned with improving the health of the Kent population. For adults this includes reducing smoking prevalence commissioning services for people with unhealthy weight, generally increasing rates of people participating in regular physical activity, the Kent wide roll out of the healthy club, the continued implementation of NHS health checks and provision of specific health trainers services to meet needs of people in the most deprived wards in Kent.**			
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Review of all adult health improvement services currently commissioned**			
1.1	Adult health improvement commissions and manages four key programmes • stop smoking and tobacco control services • health checks • healthy weight • increasing physical activity There will be planned reviews of the contracts in the first six months of the year in order to reshape and to reflect new priorities.	Marion Gibbon	March 2013	September 2013
1.2	Undertake a re-procurement exercise for services	Marion Gibbon	September 2013	March 2014
2	**Continue Implementation and rollout of "Towards a Smokefree Generation" (Kent Tobacco Control Strategy 2010-2014); supporting the National Tobacco Control Strategy (2011)**	There is a lot on tobacco control / smoking cessation		

2.1	Establish a Kent Tobacco Control Board to oversee a programme of interventions to realise benefits identified from the NICE Return on Investment tool.	A Gregory	April 2013	on-going
2.2	Establish the costs of tobacco, and benefits to denormalising tobacco in Kent; including cost of house fires, cleaning up smoking related litter and the costs associated with the criminal trade in illegal tobacco.	A Gregory	April 2013	On-going annual review
2.3	Provide support to Clinical Commissioning Groups to address tobacco control in the context of reducing rates of respiratory disease, coronary heart disease, cancer and improving child health.	A Gregory		
2	**Engage and support partners to reduce smoking in pregnancy prevalence.**			
2.1	Audit of current SATOD (Smoking at time of delivery) activity	A Gregory	April 2013	May 2013
2.2	Redesign pathways and interventions with midwifery, cessation services and others to reduce Smoking in pregnancy. E.g. babyClear programme.	A Gregory	November 2012	Review progress September 2013
3.0	**Develop smokefree living initiatives that focus on a community based approaches to reducing children's (under five) exposure to tobacco smoke.**	A Gregory		
3.1	Undertake a community based asset initiative to demonstrate the effective delivery of a second hand smoke intervention (within Dartford, Gravesham and Swanley).	A Gregory		
4.0	**Continue to lead the delivery of the "Reframe The Debate" principles by partners; supporting young people's awareness of, and education in, tobacco issues; e.g. Truth campaign from the US.**	**A Gregory**		
4.1	Commission quality tobacco education	A Gregory		

	resources to be developed and rolled out across Kent Schools.			
4.2	Co-produce with young people, quality tobacco control resources for Youth settings across Kent.	A Gregory		
4.3	Deliver youth advocacy initiatives and campaigns across Kent; directly supporting young people to take action against tobacco amongst their peers and communities.	A Gregory		
5.0	**Engage the full range of Kent partners to tackle cheap and illegal tobacco in our communities and address the criminal activity in its supply.**	**A Gregory**		
5.1	Understand the extent and nature of cheap and illegal tobacco in Kent; developing a 'problem profile'.	A Gregory		
5.2	Tackle supply of cheap and illegal tobacco through the establishment of enforcement and partnership working protocols with Trading Standards, HMRC, Kent Police and others.	A Gregory		
5.3	Tackle the demand for cheap and illegal through shifting social norms; engaging communities to prioritise action.	A Gregory		
6.0	**Lead the development of targeted workplace smokefree initiatives with district partners; providing economic savings for businesses by promoting smokefree policies and supporting workers who want to quit smoking.**	**A Gregory**		
7.0	**Lead a Health Inequalities and Wellbeing Impact Assessment of commissioned stop smoking services; identifying "commissioning best outcomes".**	**A Gregory**		
8	**Healthy Living / Healthy Weight** **Waiting for more information**		December 2012	April 2013
8.1	The procurement of a Tier 3 service as agreed with Clinical Commissioning Groups will complete the Healthy Weight Pathway and help to reduce diabetes and other conditions	Marion Gibbon	April 2013	June 2013

	in high risk groups			
9	**Roll out the Healthy Passport Club across Kent**	Marion Gibbon		
9.1	Launch the Healthy Club across Kent	Marion Gibbon	April 2013	June 2013

KEY MILESTONES		DATE (month/year)
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ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
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PRIORITY 2: Health Improvement – Child Health Programme		**DESCRIPTION OF PRIORITY: Public Health services are provided for children and young people aged 5-19 and provides prevention and early intervention services appropriate for the target group to significantly enhance a child or young person's life chances.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Review of all child health improvement services currently commissioned**			
1.1	Child health improvement commissions and manages five key programmes • School nursing • Healthy Schools Programme • Healthy Weight Programme • Teenage Pregnancy Programme	Sue Xavier	April 2013	September 2013

	• Young people sexual health services There will be planned reviews of the contracts in the first six months of the year in order to reshape and to reflect new priorities.				
1.2	Undertake a re-procurement exercise for services	Sue Xavier	Undertake a re-procurement exercise for services	Dr	Septem
2	**Reducing teenage pregnancy**				
2.1	Develop and launch guidance on good practice for the delivery of the Kent Teenage Pregnancy Programme particularly at district level	Sue Xavier	April 2013	September 2013	
2.2	Develop a specific action plan for Maidstone	Sue Xavier	April 2013	June 2013	
2.3	Implement the Maidstone plan	Sue Xavier	June 2013	March 2014	
	Should there be something more regarding overall service delivery in this service area?				
3	**Young People's Sexual health**				
3.1	Review the commissioning arrangements for the 'C Card'	Sue Xavier	June 2013	September 2013	
	Separate the commissioning of YP sexual health services and align with integrated youth services				
4	**Child Protection**				
4.1	Contribute to and participate in the implementation plan consequent to the December 2012 OFSTED inspection of child protection arrangements across Kent.	Meradin Peachey			
4.2	Needs assessment of children in need reviewed	Sue Xavier	April 2013	July 2013	
4.3	Review of the evidence of 'safe sleeping' campaign and commission new programmes	Sue Xavier	April 2013	September 2013	

5	**Multi-agency Children Services**			
5.1	Participate in the Steering Group with oversight of the review of Kent Children's Centres and the implementation of the change Programme	Sue Xavier	April 2013	March 2014
5.2	Participate in the Kent and Medway Steering Group to locally deliver the Health Visitor Development Programme to 2015 and to ensure proper interface of re-vamped health visitor services with Kent Children's Centres.	Sue Xavier	April 2013	March 2014
5.3	Ensure oversight and continuity of the commissioning of children's services within the reformed health service systems ensuring coherence as regards between KCC Commissioning and CCG Commissioning	Sue Xavier	April 2013	March 2014
5.4	Ensure public health engagement with the business of the twelve local children's trusts across Kent.	Sue Xavier	April 2013	March 2014
5.5	Re-specify the Kent Children's Multi-Agency needs assessment and complete refresh	Sue Xavier	April 2013	May 2013
5.6	Manage the promotion of health improvement messages to young people through Youthbyte creatives and apps available in schools	Debbie Smith		
6	Development Health Visitor programme to meet needs of the population and of Kent, joint commissioning with National Commissioning Board			
7	**School Nursing**			
	Engage with schools on the new healthy child programme (5-19)and review the specification for the service as a result of engagement with schools	Debbie Smith	August 12	
KEY MILESTONES				DATE (month/year)

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ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
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PRIORITY x: Sexual Health Commissioning & Redesign **Do you want this as a separate priority?**		**DESCRIPTION OF PRIORITY: Ensure that high-quality and cost-effective sexual health services are accessible to right populations and meet national standards.**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	Commission external consultancy to map the needs of our population, establish the cost and effectiveness of west kent services seek the views of user and stakeholders and tender	Dr Faiza Khan		
2.	Develop a vision and strategic direction for Sexual Health Services.	Dr Faiza Khan		
3.	Map contraceptive services in terms of need, activity and cost. Review the quality of current provision.	Dr Faiza Khan		
4.	Develop a tender for Chlamydia Screening Pathology for Kent and Medway. Award tender to successful bidder.	Dr Faiza Khan		
5.	Map Genito-Urinary Medicine service by activity cost and need and develop a strategic plan with the National Commissioning Board to align these services with HIV services.	Dr Faiza Khan		
6.	Develop a proposal for tendering all parts of	Dr Faiza Khan		

	the Sexual Health Service.			
7.	Tender for the provision of the following: Independent Sexual Violence Adviser (ISVA); Forensic medical Examiner and; crisis workers in liaison with the police and the National Commissioning Board	Dr Faiza Khan		

PRIORITY 3: Management of Health Protection **Do you want this as a separate priority? Is there enough?**		**DESCRIPTION OF PRIORITY: Develop a health protection committee to monitor and take action on health protection and outbreak management.**		
1	Establish systems of monitoring patterns of C.Difficile and MRSA in health and social care settings.	Dr Faiza Khan		04/13
2	Develop ability to monitor the quality of screening programmes and immunisation and vaccination programmes.	Dr Faiza Khan		04/13
3	Determine internal scrutiny arrangements for health-protection plans	Dr Faiza Khan		04/13
4	Develop close working relationships with Public Health England and Kent County Council to assure the public that health protection plans are in place.	Dr Faiza Khan		04/13

KEY MILESTONES		DATE (month/year)
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ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
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PRIORITY x: Community Based Initiatives **Need to add the development programmes for the Health Living Centres**		**DESCRIPTION OF PRIORITY: To develop and deliver in partnership community based initiatives in support of health living**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**HOUSE project** (an imitative for young people to promote lifestyle messages on smoking, alcohol, drug misuse and sexual health and any other issues young people are concerned about)			
1.1	Support District councils to host a long term and sustainable HOUSE provision in town centres with partner agencies	Commissioning and Strategy Manager	April 2013	March 2014
1.2	Ensure that young people are engaged in the delivery of HOUSE and that their health and emotional wellbeing needs are listened to and considered	Commissioning and Strategy Manager	April 2013	March 2014
1.3	Oversee contract and delivery of HOUSE ON THE MOVE mobile provision of HOUSE and make sure that young people in hard to reach communities have opportunities to access HOUSE	Commissioning and Strategy Manager	April 2013	October 2013
KEY MILESTONES				DATE (month/year)
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ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?			ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No	
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PRIORITY X: Health Improvement - Health and Social Care Partnerships		**DESCRIPTION OF PRIORITY: Working with Families and Social Care Directorate the NHS and other partners to tackle health inequalities through specialist interventions**		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**To provide comprehensive public health advice to the commissioners of Learning Disability services**			
1.1	Develop a project plan and methodology for undertaking needs assessment and engage stakeholders	Malti Varshney	April 2013	July 2013
1.2	Refresh Needs assessment according to existing timetable	Malti Varshney	April 2013	July 2013
2	**Suppport transformation of Urgent Care as part of the shift to community health**			
2.1	Presentation of urgent care needs assessment at Clinical Commissioning Groups	Malti Varshney	April 2013	May 2013
2.2	Design evaluation framework of urgent care services wherever necessary produced	Malti Varshney	January 2013	March 2014
3	**Support CCGs in the development of their annual round commissioning intentions**		July 13	August 2013
3.1	Support social care commissioning of urgent care services	Malti Varshney	Feb 2013	On-going
3.2	Design preparation and analysis of utilization review	Malti Varshney and Abraham George	Sep 2013	Dec2013
4	**Introduction and delivery of a programme to reduce excess winter deaths**			
4.1	Identifying individuals at risk via community outreach work	Colin Thompson	September 2013	November 2013
4.2	Development and commissioning of	Colin Thompson	September	November 2013

	programme		2013	
4.3	Programme delivery	Colin Thompson	November 2013	March 2014
4.4	Trialling telecare in the form of cold weather alarms with people receiving home visits	Colin Thompson	July 2013	March 2013
4.5	Establishing the winter warmth support fund and oversee the delivery of appropriate support interventions	Colin Thompson	On-going	March 2013
5	**Workplace health**			
5.1	Develop and support with KCC's Human Resources team a health needs assessments around workplace health for the County Council.	Colin Thompson, Colin Miller	April 2013	May 2013
5.2	Support the development of KCC's staff Health and Wellbeing Strategy	Colin Thompson, Colin Miller	June 2013	October 2013
5.3	Promote the implementation of the Workplace Charter where appropriate, supporting SMEs and other organisations with the delivery of workplace health initiatives	Malti Varshney, Colin Thompson	May 2013	March 2014
6	**Reduce Hospital Admission through better management of trips and falls and the implementation of falls pathways**			
6.1	Work with CCGs and KCC to commission the expansion of a Falls Prevention Service in Kent building on best practice already in existence in West Kent CCG.	Karen Shaw / Malti Varshney	June 2013	April 2014
6.2	Develop and agree a clear referral pathway with stakeholders from the acute trust to the falls prevention service.		April 2013	June 2013
6.3	Develop a robust evaluation framework for an integrated falls and fracture prevention pathway including evaluation of falls prevention service.		April 2013	May 2013
6.4	Work with CCGs and adult social care around specific prevention pathways in care homes.		March 2013	August 2013

6.5	Work with Adult Social Care in identifying and training/raising awareness amongst care providers in fall prevention mainly in the care homes		March 2013	April 2014
7	**Increase public awareness about fall prevention**			
7.2	Raising public awareness through falls awareness day/month working with Age UK		July 2013	October 2013
7.3	Lead on the procuring funding for postural stability classes within the community from BIG Lottery		September 2013	March 2013
7.4	Re-writing bid and liaising directly with BIG Lottery for resubmission of bid		December 2012	January 2013
8	**Improve fall prevention within the local communities**			
8.1	Work with stakeholders in developing a more integrated whole systems falls pathway (the NHS, Local Authority, Voluntary Organisations, Patient Groups, Fire & Rescue Service, Ambulance Services, GPs and other health professionals)		April 2013	August 2013
8.2	Commission community-based therapeutic exercise programmes, commissioned to the required quality and capacity through a range of providers including local leisure services and the voluntary agencies		Dec 2012	March 2014
8.3	Commission high quality training (Laterlife) to upskill level 3 instructors to a level 4 postural stability instructors.		April 2013	December 2013
8.5	Conduct service mapping of third sector/voluntary organisations providing therapeutic exercise programmes		April 2013	May 2013
9	**End Of Life Care**			
9.1	Participation in end of life stakeholder groups in Kent	Abraham George	On-going	

9.2	Working with CCG leads to provide epidemiological analyses and commissioning support to understand end of life need – cancer vs. non cancer patients	Abraham George	On-going	
9.3	Provide PH support towards any relevant service evaluation	Abraham George	On-going	
9.4	Participation into Hospital Mortality working group	Abraham George	On-going	
10	**Long Term Conditions**			
1.1	Liaise with respective LTC leads to provide PH commissioning support and epidemiological analyses to CCGs	Abraham George	On-going	
1.2	Support implementation of Year of Care programme and research	Abraham George	On-going	
1.3	Work with urgent care leads to ensure LTC input into urgent care strategy	Abraham George	On-going	
1.4	Liaise with LTC lead to provide necessary PH commissioning support and epidemiological analyses	Abraham George	On-going	
1.5	Support implementation of Year of Care programme and research	Abraham George	On-going	

KEY MILESTONES		DATE (month/year)
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ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
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PRIORITY x : Health Improvement - Vulnerable People and Mental Health Programme (Mental Well Being and Substance Misuse)		**DESCRIPTION OF PRIORITY: This is a core and underpinning public health priority and has impact across all KCC directorates. However best practice guidance suggests that public mental health must be specifically identified in all programmes to have desired impact and this is overarching aim of this programme. The key outcomes are a reduction in suicide in all borough councils in Kent, increased reported well-being and increased access to IAPT services.**		
		Substance Misuse services are commissioned services in KCC and there is an established team delivering these via corporate plan in Customer and Community Directorate. The public health priority is to ensure that preventative services are equitable, delivering to outcomes and aligned to CCGs and districts needs.		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Improve Mental Well Being**			
1.1	Manage Partnership relationships of '5 Ways to Being: Live it Well" Group (Kent's mental Health Strategy	Bose Jonson		03/14
1.2	Work with public health commissioned services to embed well being as core	Jess Mookherjee	April 2013	June 2013
1.3	Deliver mental well being impact assessment in Districts across Kent	Bose Johnson	April 2013	March 2014
1.5	Deliver pilot for improvement of quality of pharmacy services across Kent	Jess Mookherjee	July 2013	March 2014
2	**Work with CCGs to ensure mental health well being commissioning is aligned**			
2.1	Review Live it Well re public mental well being impacts according to need	Bose Johnson	April 2013	July 2013
2.2	Conduct Asset Mapping for Well Being with Districts and Across Kent	Bose Johnson	April 2013	August 2013
2.3	Manage partnerships across districts and CCGs regarding prioritisation of needs of vulnerable groups	Jess Mookherjee	07/12	04/13

2.4	Review and audit key mental health interventions for CCGs	Jess Mookherjee	April 2013	March 2014
2.5	Complete research audits on medically unexplained symptoms across Kent and improve service pathway	Jess Mookherjee/ Natasha Roberts	April 2013	November 2013
3	**Implement Kent and Medway Suicide Prevention Plan**	Bose Johnson		
3.1	Map training plan for Kent	Bose Johnson	April 2013	April 2013
3.2	Review progress on self harm audits across Kent hospitals	Bose Johnson	June 2013	December 2013
4	**Improve well being and service access for vulnerable communities**	Jess Mookherjee		
4.1	Identify partnership programmes which will improve veteran health	Jess Mookherjee	April 2013	January 2014
4.2	Work with probation services to improve outcomes for offenders and victims	Jess Mookherjee/ Stephen Cohrane		
4.3	Input public health expertise via data and needs assessments and evidence for improvements to Adolescent mental well being services	Jess Mookherjee	April 2013	March 2014
5	**Support to NCB LAT/ PHE re Forensic Mental health or specialist services as needed e.g. dual diagnosis / eating disorders**	Jess Mookherjee		
6	**Provide strategic public health leadership for substance misuse services straddling CCGs and KCC**	Jess Mookherjee		
6.1	Renew and refresh the Alcohol Strategy			
	Ensure data, audits and needs assessments for substance misuse are up to data and accurate	Colin Thompson	April 2013	January 2014
	Work with CCGs to establish robust pathways for alcohol identification and treatment	Colin Thompson	April 2013	January 2014
KEY MILESTONES				DATE (month/year)
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ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
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PRIORITY x: Health Intelligence and Operational Research		**DESCRIPTION OF PRIORITY:** Health Intelligence and Operational Research provides the evidence base for public health interventions and health service commissioning. It is also responsible for producing two statutory documents, the Joint Strategic Needs assessment (JNSA) and the Director of Public Health Annual report. Most of the work of the team is onging and includes Needs Assessments [Population, wider determinates, disease specific etc.], Health Equity Audits, Health Impact Assessment Evaluation, Library and Knowledge Management, Evidence Reviews		
Actions		Accountable Officer	Start Date (month/year)	End Date (month/year)
1	**Joint Strategic Needs Assessment (JNSA)**			
1.1	JSNA process paper to HWBB		December/12	January/13
1.2	Establish JSNA Steering Group	Abraham George / Natasha Roberts	Jan/13	On-going Qtrly
1.3	Develop prioritisation tool for programme of needs assessments	**Natasha Roberts**	**Jan/13**	**March/13**
1.4	Agree prioritisation tool at JSNA Steering group	Natasha Roberts	March/13	March/13
1.5	Implement a programme of needs assessments	Natasha Roberts	April/13	March/14

1.6	Implement refresh and review process for existing needs assessments		April/13	March/14
2	**Annual Public Health Report**			
2.1	Identify topics Annual Public Health Report		November/12	December/12
2.2	Write APHR chapters		**Jan/13**	**March/13**
2.3	Communications and distribution strategy for APHR		**Jan/13**	**March/13**
2.4	Design and publish APHR		**April/13**	**June/13**
1.4	Distribute APHR		**June/13**	**June/13**
3.	**Review and Develop Health and Social Care Maps**		**November/12**	**March/13**
1.	**Questionnaire to existing and future users**		**November/12**	**December/12**
2.	**Analysis of results**		**December/12**	**December/12**
2.1	Review of results at HSCM Steering group		December/12	December/12
3.	**Redesign of HSCM**		**Jan/13**	**June/13**
3.1	Restructure existing HSCM to reflect agreed structure		Jan/13	March/13
3.2	Options appraisal paper for IT/software solutions		Jan/13	March/13
3.3	Agree proposed IT solution/ software solution			March/13
3.4	Implement IT/software solution		March/13	June/13
4.	**Re-Launch of Health and Social Care Maps**		**June/13**	**June/13**
4.1	Workshop to demonstrate and talk key stakeholders through the HSCM [CCGs, District Authorities etc.]		June/13	June/13
4.2	Presentation at team meetings		June/13	September/13
4.3	Quarterly newsletter / up-date			On-going

KEY MILESTONES		DATE (month/year)
A	JSNA is available at District and CCG levels to inform organisational commissioning intentions	Sept/13
B	Health and Well-being board proposed JSNA process	Jan /13
C	Agreement of prioritisation tool	March/13
D	APHR Published	June/13

ARE THERE ANY KEY OR SIGNIFICANT DECISIONS THAT COULD ARISE FROM THIS PRIORITY?		ARE THESE ALREADY IN THE FORWARD PLAN? Yes/No
1		
2		
3		

SECTION D: FINANCIAL AND HUMAN RESOURCES

For the Financial Resources section **Finance** will provide the required information and detail that sets out the main components of your budget by completing the table below.

FINANCIAL RESOURCES

Divisional Unit	Responsible Manager	Staffing	Non Staffing	Gross Expenditure	Service Income	Net Expenditure	Govt. Grants	Net Cost
		£	£	£	£	£	£	£

HUMAN RESOURCES		
FTE establishment at 31 March 2013	**Estimate of FTE establishment at 31 March 2014**	**Reasons for any variance**

SECTION E: RISK & BUSINESS CONTINUITY

RISKS	
RISKS	MITIGATION

BUISNESS CONTINUITY		
CRITICAL FUNCTIONS	TIMESCALE	MINIMUM SERVICE LEVEL

SECTION F: PERFORMANCE AND ACTIVITY INDICATORS

With the transition of Public Health to KCC a new set of performance indicators will need to be generated that satisfies both KCC's needs as well as allows reporting against the national Public Health Outcomes Framework. This work is in train.

Table for PERFORMANCE indicators measurable annually by financial year

PERFORMANCE INDICATOR - ANNUALLY BY FINANCIAL YEAR	Floor Performance Standard	2012/13 Outturn	Comparative Benchmark	Target 2013/14	Target 2014/15

SECTION G: ACTIVITY REQUIRING SUPPORT FROM OTHER DIVISIONS/SERVICES
(For example Property, ICT, Business Strategy, Human Resources, Finance & Procurement, Planning & Environment, Public Health, Service Improvement, Commercial Services, Governance & Law, Customer Relationships, Communications & Community Engagement or other Divisions/Services)

ACTIVITY DETAILS	EXPECTED IMPACT	EXPECTED DATE

By: Graham Gibbens, Cabinet Member for Adult Social Care & Public Health

Meradin Peachey, Director of Pubic Health

To: Social Care and Public Health Cabinet Committee – 11 January 2013

Subject: **Public Health 23 Programmes**

Classification: Unrestricted

Summary: This report provides an overview of the 23 programmes and services which are transitioning to the responsibility of Kent County Council from April 2013. This report also sets out commissioning intentions for 2013/14 subject to NHS budget allocation

For Decision: The Cabinet Committee are asked to consider this report, note the contents and either endorse or make further recommendations for the transition and commissioning of the 23 Public Health programmes and services to Kent County Council.

Introduction

1. (1) This report builds upon previous reports to the now decommissioned Adults Social Care and Public Health Policy Overview and Scrutiny Committee and to the Social Care and Public Health Cabinet Committee regarding the national changes to the public health system and the movement from the National Health Services to Upper Tier Local Authorities. The report summarises each of the 23 programmes and services coming to the County Council and highlights future commissioning intentions. Key changes have previously been agreed through this committee.

Health and Social Care Bill - 27 March 2012

2. (1) The enactment of the Health and Social Care Bill gives KCC, as an upper tier Authority, a new duty "to take appropriate steps to improve the health of the people."

(2) As well as the Act introducing a generic duty, it also requires KCC to undertake a number of specific steps including:

- Establishing a Health and Wellbeing Board
- The development of an enhanced Joint Strategic Needs Assessment (JSNA) under the auspices of the Health and Wellbeing Board
- Commissioning Kent HealthWatch
- Assuming statutory responsibility for some of the key elements of the new national Public Health System

- Appointing (by statute) a Director of Public Health

(3) The Act introduces a new national Public Health system consisting of four elements:

- National Commissioning Board
- Public Health England
- Clinical Commissioning Groups
- Upper Tier Local Authorities

(4) In effect, this means that KCC becomes an integral part of this new national system providing locality-led leadership and oversight of Public Health (PH) in the County, together with responsibilities in delivering some key PH services from the 1 April 2013. To support these new responsibilities the Authority will receive a ring-fenced budget and the transfer of most of the existing NHS staff currently working in PH in Kent. At the time of writing this report the notification of NHS budgets including PH allocation to LAs was still awaited.

23 Public Health Programmes and Services

3. (1) The transfer includes the shaping and delivery of 23 Public Health programme/services of which, going forward, the following will be mandated from next year:

- Appropriate access to sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention).
- Steps to be taken to protect the health of the population, in particular giving the local authority a duty to ensure there are plans in place to protect the health of the population.
- Ensuring NHS commissioners receive the Public Health advice they need.
- NHS Health Check assessments.
- The National Child Measurement Programme.

(2) Outside of these mandated services, other services will be discretionary (although the Secretary of State holds reserve powers over the direction of other services) with the Health and Well Being Strategy and the JSNA guiding delivery against these other areas. However, performance will also be judged against the national Public Health Outcomes Framework which will influence the allocation of future resources through the proposed Public Health premium system.

(3) The Act also makes it clear that the Authority has a responsibility for taking appropriate steps to protect the health of the population and to ensure the safety of Public Health services.

4. (1) The accompanying report sets out for each of the 23 programmes and services:

- What the programme or service is
- Who is it for
- The Contracted provider(s)
- The evidence base for the service
- Targets and Outcomes
- Issues, Gaps and Opportunities
- What is the cost and what we get for the money

(2) Please note that a good number of programmes do not have budgets attached to them, but rather are delivered through the advice Public Health Consultants and their teams provide to the "system"

(3) At the time of writing, Public Health continue to work with the Local Area Team of the National Commissioning Board and with Clinical Commissioning Groups to identify and confirm how Public Health will work with these bodies in the future. Thus the outline of these programmes is subject to on-going change as the detail is clarified.

Commissioning Intentions 2013/2014

5. (1) Our intention is to roll the majority of existing contracts with our providers giving us collective time to prioritise and systematically review each and every contract following the novation to Kent County Council.

(2) However, the Social Care and Public Health Cabinet Committee have previously agreed the following changes which are currently being implemented:

- Health Checks to be commissioned county wide via the Kent Community NHS Healthcare Trust
- The procurement of more efficient diagnostic costs in the Chlamydia screening service
- The commissioning and procurement of a new genitourinary medicine service for the north Kent area, following Dartford and Gravesham NHS Trust serving notice.

Finance and Budgets

6. (1) After April 2013, PH and the 23 programmes and services will be funded through a new Public Health budget, essentially a ring-fenced grant to upper tier and unitary authorities. Announcements of the actual budget are expected to be made by the NHS before Christmas 2012 and a verbal update on the position will be made to the Social Care and Public Health Cabinet Committee.

(2) Detailed analysis work through Finance Departments of PCTs and the County show that the current total expenditure on the 23 PH programmes and services is in the order of £43.6m.

Conclusion

7. (1) This report informs the Committee of the detail behind the 23 Public Health programmes and services being transferred to the County Council from April 2013. It seeks endorsement by the Committee in the Cabinet Member for the approach of a prioritised systematic review of Public Health contracts for 2013/14 and beyond over and above previous commissioning decisions which the Cabinet Committee has previously taken.

Recommendations

8. (1) To note the detail of the 23 Public Health programmes and services which become the responsibility of the County Council from April 2013

(2) To endorse the Cabinet Member's approach to roll existing contracts with a prioritised and systematic review through 2013/14 and beyond, with the exception of the programmes previously agreed by this Cabinet Committee.

Background Documents

None

Contact details

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Public Health Factsheets

Meradin Peachey – Director of Public Health

December 2012

Version	Status (Draft or Approved)	Date	Author/Editor	Details of changes
1.0	Draft	23/12/2012	Natasha Roberts	Initial draft of the 23 programmes of public health
1.1	Draft	07/12/12	Natasha Roberts	Addition of a title, notes and contents page. Amendments to factsheets 16,19, 20, 21, 22 and 23. Minor changes to the Target and outcomes sections in all appropriate factsheets
1.2	Draft	12/12/12	Natasha Roberts	Added an additional paragraph to factsheet 20.
1.3	Draft	19/12/12	Natasha Roberts	Replacement of factsheet 11.0 Dental Public Health

Prepared by	Natasha Roberts – Head of Health Intelligence	Next review: January 2013

Notes:

- The costs contained within the factsheets reflect what is currently known about the cost of the existing services. The costs do not reflect what the public health budget allocation will be for 2013-14.
- These costs will be revised and the factsheets reissued when the budget are allocated.
- The advice and support to National Commissioning Board is still being worked through the factsheet represents possible advice and support
- The advice and support to Clinical Commissioning Groups is still being worked through the factsheet represent possible advice and support

Contents

1.0 Tobacco Control and Smoking Cessation

What is the service?

Offering brief advice to stop smoking is the single most cost-effective and clinically proven preventive action a healthcare professional can take.
Smoking prevalence in Kent is 24.9%, and it is a major reason for our health inequalities. Helping people to stop smoking is a key part of the business of NHS services across Kent. PCTS set and achieve targets around successful smoking quitters as measured by four week quitters.

Who is it for?

The population groups are those in the general population who smoke and includes both adults and children and young people.

The contracted provider or providers if there are multiple

The service is delivered by Kent Community Healthcare NHS Trust, via one to one advisers, group sessions, and structured sessions at specific venues and referrals from community and hospital staff. There are also stop smoking services provided in offender institutions such as prisons. Some Healthy Living Centres also offer some stop smoking services.

National Evidence

- Smoking is an important cause of cancer, respiratory disease and coronary & circulatory diseases. Smoking is a major health inequality issue within Kent, contributing to the difference in life expectancy gap between more and less deprived wards. 2,000 deaths of people aged 35 or over in Kent in 2008 can be attributed to smoking with 7 years in losses to life (Kent and Medway PHO, 2009).
- There are more than 4000 chemicals in tobacco smoke, of which at least 250 are known to be harmful and more than 50 are known to cause cancer. (World Health Organisation)
- Globally, tobacco use kills around 6 million people every year (World Health Organisation).
- Smoking has been recognised as the leading cause of poverty, preventable illness and untimely death in the UK, killing over 80,000 people annually.
- Smoking costs the NHS approximately £2.7 billion every year (A Smoke free Future; Department of Health 2010). There are over 10,000 admissions to our hospitals each year which are due to smoking. This is estimated to cost NHS Eastern and Coastal Kent £12m and NHS West Kent £10m each year.
- The annual outpatient activity costs associated with smoking in East and West Kent are estimated to be £1.3m and £860,000 respectively.
- Tobacco control plan for England set out national ambitions to reduce adult smoking prevalence in England from 21.2 % to 18.5 % or less by the end of 2015; reduce rates of regular smoking among 15 year olds in England to 12 % by the end of 2015; and the rates of smoking in pregnancy from 14% to 11% by the end of 2015. (Healthy lives, healthy people: a tobacco control plan for England, 2011).

NICE have produced the following smoking pathway please follow link Smoking pathway

NICE has issued the following related technology appraisal guidance and clinical guidelines.

- Guidance on the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation. NICE technology appraisal guidance 39 (2002). [Replaced by NICE public health programme guidance 10]
- Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health intervention guidance 1 (2006).
- Workplace health promotion: how to help employees to stop smoking. NICE public health intervention guidance 5 (2007).
- Smoking cessation services. NICE public health programme guidance 10 (2007).
- Guidance on the use of varenicline TA123
- Preventing the uptake of children and young people PH14
- Quitting smoking following pregnancy and childbirth PH26
- School based interventions to stop smoking PH23
- Smokeless tobacco prevention among Asians PH39

Target and Outcomes

National Outcome measures

2.3 Smoking status at time of delivery

- The proportion of women smoking at delivery in Kent is 16.8% significantly more than England 13.5%

2.9 Smoking prevalence -15 year olds

- Data collection for this indicator is still being developed

2.14 Smoking prevalence – adults (over 18s)

- The prevalence of adult smoker in Kent is 21.3% no significantly different to the England rate 20.7%

Quit Target

The target agreed with Public health for people who have set a quit date and successfully quit at four week follow-up was 2007. 2021 quitters were achieved. £2.61m has been invested into Smoking Cessation in Kent.

Kent Public Health Action

- Work closely with GPs and pharmacists to provide a wide network of in-house support
- Social Marketing – Focus on routine & manual groups
- Specialist support was also available for pregnant women and their families.
- Continuing to enforce smoke-free public places
- Ensure appropriate services to meet smokers' preferences
- The control of illicit tobacco and supply of tobacco to under-18s

Issues, Gaps and Opportunities

- Increased focus on primary and secondary care and frontline Council services is required, particularly in ensuring sufficient and appropriate staff are trained in Brief Intervention, good quality Brief Advice/Intervention is given, and that referrals to stop smoking services are made proactively.
- The Health Trainer resources in West Kent are limited. A consideration of how health improvement and health promotion resources are deployed across Kent to ensure that inequities are addressed needs to be undertaken.
- A reliance on national synthetic estimates for smoking prevalence needs to be addressed, either through a more localised Health Survey for England or the development of local data collections. Evidence base needs to be improved through local surveys
- There is a need to raise awareness of tobacco control beyond health and highlight the impact of other agencies and departments, including: fire and rescue; housing; social care; and human resources.
- Continued focus by midwifery services and Stop Smoking Services of Kent Community Health is required to help motivate women to give up smoking prior to or early in pregnancy.
- There is a lack of young people involvement in the development of local smoke-free campaigns.

What is costs and what we get for the money

Smoking Cessation Investment- £2.61m

2.0 and 3.0 Drug and Alcohol Services

What is the service? Alcohol and Drug Services : identification, support and Treatment in Kent.

There are a number of services that are commissioned : these are

- advice, sign posting and brief advice
- substance misuse detoxification services
- counselling and support services for young people
- services for detoxification and recovery in prisons
- drug and alcohol intervention services in probation and custody
- youth offending drug intervention programmes
- peer support and advocacy
- needle exchange and blood borne virus treatment and screening.

Who is it for?

The services described below are for adults and young people needing drug and alcohol treatment and advice in Kent. These services are for people (and carers) who need open access or structured interventions for misuse of alcohol or illegal drugs and/or misuse of prescription drugs and legal substances (excluding tobacco).

42% of all service users are opiate and crack users.
15% of services users are alcohol dependent.
Large majority of all service users have both drug and alcohol problem.

Approximately 5,555 people used the service in 2011/2012

There is a public health needs assessment which says this is the expected number for drug services but dependent alcohol drinkers are somewhat under represented.

The contracted provider or providers if there are multiple

Currently there are two separate services provided for east and west Kent. This is due to historic commissioning focused on east and west Kent PCT. moving forward: the commissioning intentions are streamlined to a Kent Wide Service.

Currently west Kent's providers are :
CRI and RSA

East Kent providers are
KCA, Turning Point and CRI

East Kent is currently out to tender and the results of this tender process will be announced shortly.

The provider for young people's services across the whole of Kent is:
KCA and this is a both a generic prevention as well as specialist treatment service.

National Evidence

Psychosocial interventions
Department of Health (2007) Drug misuse and dependence: UK guidelines on clinical management. Available at:
http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

Department of Health (2007) Reducing Drug-related Harm: An Action Plan. Available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074850

National Treatment Agency for Substance Misuse (2006) Models of care for treatment of adult drug misusers: Update. Available at:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_085895.pdf

NICE (2007) Drug misuse: opioid detoxification (CG52) Available at:
http://www.nice.org.uk/nicemedia/live/11813/35997/35997.pdf

NICE (2007) Psychosocial interventions (CG51) Available at:
http://www.nice.org.uk/nicemedia/live/11812/35973/35973.pdf

NICE (2009) Needle and syringe programmes: providing people who inject drugs with injecting equipment (PH18) Available at: http://www.nice.org.uk/nicemedia/live/12130/43301/43301.pdf

NICE (2011) Alcohol-use disorder: the NICE guidelines on diagnosis, assessment and management of harmful drinking and alcohol dependence, Available at:
http://www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf

NICE(2011) Psychosis with coexisting substance misuse: assessment and management in adults and young people (CG120) Available at:
http://www.nice.org.uk/nicemedia/live/13414/53729/53729.pdf

NICE (2012) NICE quality standard on drug use disorders (QS23) Available at:
http://guidance.nice.org.uk/QS23

Target and Outcomes

There are a number of key targets relating to drug and alcohol within the Public Health Outcomes Framework (PHOF)

National Outcome measures
1.13 Re-offending and social connectedness (placeholder)

- The percentage of offenders who re-offend from a rolling 12 month cohort 2010, Kent 25.1% lower than the England rate of 26.8%
- Average number of re-offences per offender 2010, Kent 0.7 per offender, lower than that for England 0.8 per offender
- Data on social connectedness is not currently available as the indicator is still in development.

2.7 Hospital admissions to young people due to uninterested and deliberate injuries

- data set to be developed

2.15 Successful completion of drug treatment

- Successful completion of drug treatment 2010, Kent 24.4% significantly higher than that for England 12.3%

2.18 Alcohol related admissions to hospital

2.16 People entering prison s with substance misuse problems previously not known to services.

2.22 Take up of the NHS Health Checks Programme

- In addition Health Checks are asking for information on alcohol misuse.

2.23i Self-reported well-being a low satisfaction score

- The rate for Kent is 21.3% significantly lower than that for England 24.3%

2.23ii Self-reported well-being low worthwhile score

- The rate for Kent is 15.7% significantly lower than that for England 20.1%

2.23iii Self-reported well-being high anxiety score

- The rate for Kent is 37.8% which is not significantly different to the England rate 40.1%

4.6 Mortality from liver disease

- Under 75 mortality rate from liver disease 2009-11, Kent 11.5 per 100,000 population lower than that for, England 14.4 per 100,000 population.
- Under 75 mortality rate from liver disease that is considered preventable 2009-11, Kent 11.6 per 100,000 population, the same as England 11.6 per 100,000 population.

There is a recent and up to date needs assessment for substance misuse and there is also a raft of needs assessments relating to the health of the offender population in prisons, custody and in the community.

Current performance against outcomes:

The previous outcome target was LAA NI39 target to prevent the rise of alcohol attributable hospital admissions. This is a synthetic estimate and not based on actual data. Therefore better coding of conditions such as hypertension mean that the attribution of increased hospital attendances for such conditions show a rise across Kent on that indicator. The recommendation is to use a more useful outcome measure as detailed in the PHOF.

The recent needs assessment shows variations across Kent for binge drinking, alcohol related admissions and alcohol specific deaths. The hotspot areas are Thanet, Maidstone and Tunbridge Wells.

The recent needs assessment shows that the performance indicators for the KCC commissioned services to the NTA (now PHOF) measures showed Kent performed in the top 10% of commissioned services in England.

Needs assessment for adults link:
http://www.kmpho.nhs.uk/easysiteweb/getresource.axd?assetid=235133&type=0&servicetype=1

needs assessment for children link:
http://www.kmpho.nhs.uk/EasysiteWeb/getresource.axd?AssetID=201614&type=full&servicetype=Attachment

Issues, Gaps and Opportunities

A. There are historical commissioning issues based on differences between east and west Kent PCT's that will need to be smoothed out in time.
B. the prescribing costs for the service have been underestimated and not factored into the public health baseline cost of £18 million. This is a risk as the PH budget may have to top up costs in rising prescribing budget.
C. The current budget for KCC services is pooled from a variety of funding sources and the current commissioning intentions from the PCC budget are unknown and any changes may impact on the Drug intervention project.
C. In the past this budget has been ring fenced and prioritised due to importance given to the national treatment agency and its link to criminal justice. This budget is no longer ring fenced but the outcome targets are still prominent.
D. There is no current funded programme for Brief Advice in GP surgeries and hospital A&E, data collection is poor at A&E and attention here can enable impact on community safety and long term conditions.
E. there is opportunity via Health Checks and overall budget for lifestyle services to work more closely with KCC commissioned services to align outputs and outcomes for alcohol prevention.
F. There is a need to target Thanet's outcomes for dependent drinkers and working with local partnerships in Thanet will be good.

What is costs and what we get for the money

Total spend £18.8 million
Of that - £10.9 million is badged as public health however the manor of commissioning is pooled between another two funding sources - home office (now Police Crime Commissioner) and KCC

For £1O million (approx.) we get a pooled prevention, support and treatment package across Kent for children and adults, linked and aligned to crime agenda and police commissioning. In addition there are excellent links to local districts via crime strategic partnerships who take forward the local alcohol strategy arrangements.

The national alcohol strategy for England prioritises alcohol related disorder, licensing arrangements and binge drinking. There is a successful Kent community Alcohol Pilot which is led by public health, police and trading standards. Key areas for further work are alcohol pricing, responsibility deal, town centre and binge drinking monitoring and healthy lifestyle messaging via healthy passport and other public health interventions. In addition working with pharmacies and GPs and hospitals is also in the new Kent Alcohol Strategy.

Therefore the £18 million also buys excellent partnership arrangements via public health expertise and KCC commissioning expertise, needs assessments, targeted service design and monitoring.

4.0 Public Health services for Children & Young People aged 5-19 and the Healthy Child Programme

What is the service?

The Healthy Child Programme (HCP) is a progressive universal programme that sets out the good practice framework for prevention and early intervention services appropriate for all children and young people aged 5–19 and recommends how health, education and other partners working together can significantly enhance a child's or young person's life chances. This is school nursing.

School Nursing Services offer a significant resource to children, young people and schools in delivering a core public health service within schools settings and where possible through wider community settings. A Consultation with Kent schools and School Nursing Services is commencing to ensure that the national and local direction for universal and enhanced services will result in improved services in the future.

The Healthy Schools programme works with schools to provide an environment that enable health behaviours and development

Who is it for?

The HCP good practice guidance is for all organisations responsible for commissioning services for 5–19-year-olds' health and wellbeing as well as frontline professionals delivering those services.

There are specific groups within the 5 to 19 age range who may require more support and/ or intervention

Disabled children and their families – Public Health works with a range of interests and partners to promote the life chances of this group of children and young people.

Child protection [Safeguarding] Kent Public Health has a key role to play in the Kent Child Safeguarding Board.

Young Carers
Young Carers' Projects aim to provide relief from isolation. It is estimated that there are 2,773 young carers in Kent. Much of young carers' support comes from the voluntary sector. Public Health's role is to ensure that those groups are financially maintained and to support the general advocacy of this group of children, many of whom through unfair circumstances have had caring responsibilities thrust upon them.

Adolescence
The great majority of adolescents are not problem people with problem lives, but face the same difficulties as everyone else. Public Health has a responsibility for ensuring that there are appropriate services to address these needs and that such services demonstrate particular empathy with adolescent attitudes and behaviours.

Housing, Homelessness and Young People
Generally there is much mis-understanding about youth homelessness not helped by policies of successive Governments. Public Health has a key role in working with local housing authorities to try to meet a whole range of complex needs and demands concerning this aspect of young people's lives.

School Nursing
Is provided to all children and young people in Kent between the ages of 5-19. School Nursing Services are predominantly delivered in school settings although wider community settings are encouraged to increase accessibility to vulnerable young people.

School Nurses are required to work with Head Teachers and teaching staff in schools, with parents where appropriate and with Enhanced Healthy Schools and other School Health Teams. Partnership working with Health Visitors is also paramount to assist the transition of young children into primary school.

The contracted provider or providers if there are multiple

Kent Community Health Care Trust (KCHT) are the providers of the Healthy Child Programme (HCP) School Nursing Services in some areas of Swale are currently provided by Medway Foundation Trust, but future services in these areas are being reviewed as part of the imminent Kent School Nursing consultation.

KCHT also provide the healthy school s programme.

National Evidence

Guidance is provided by the Department of Health

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108866.pdf

Key strategic documents include:

- Children Act 2004
- Every Child Matters
- NSF DH 2004
- National Child Health Strategy, 'Healthy Lives, Brighter Futures' DH/DCSF 2009
- Apprenticeship, Skills, Children and Learning Act 2009
- Vision and Call to Action: Getting it right for Children, Young People and Families

Target and Outcomes

Key Health Priorities in the HCP

- Health inequalities
- Emotional health, psychological wellbeing & mental health
- Promotion of healthy weight
- Longstanding illness or disability

- Teenage pregnancy & sexual health
- Drugs, alcohol & tobacco
- Safeguarding

Additional School Nursing Key Health Priorities:

- Reduced tooth decay in Children aged 5
- Reduced Hospital admissions due to unintentional or deliberate injuries
- Improved vaccination cover
- Improved readiness for school
- Reduced school absences

There is a planned Children's Outcomes Framework.

Issues, gaps and Opportunities

Public Health is intending to lead a consultation with Kent Schools and School Nursing Services to review the experiences of children, young people, schools and School Nurses in Kent to ensure that future services are commissioned and delivered around identified needs to be provided within current resources.

What is costs and what we get for the money

School nursing services cost £1,236,021 west Kent and £2,431,370 East Kent
Kent County Council Healthy schools team £233,130
west Kent Services will be reviewed through the Kent consultation exercise to determine need, quality of services and value for money.

5.0 National Child Measurement Programme

What is the service?

The National Child Measurement Programme (NCMP) is an annual programme to measure the height and weight of all children in Reception and Year 6. The aim of this programme is to provide national statistics on obesity with a target of measuring at least 85% of these eligible children and to help to plan and provide better health services for children.

The programme has been running since 2006/07 academic year.

Who is it for?

- The programme measures the height and weight of Reception and Year 6 children
- This information is shared with parents and carers through a letter.

The contracted provider or providers if there are multiple

Kent Community Health Care Trust is commissioned to deliver the NCMP.

National Evidence

Guidance is provided annually and is non-mandatory.
https://www.education.gov.uk/publications/eOrderingDownload/NCMP%20schools%20guidance%202011-12.pdf

The guidance covers

- Equipment
- Training
- Measuring methods
- Data
- Confidentiality
- Letters and Communication
- Handling Complaints

Target and Outcomes

National Outcome Measures
2.6 Excess weight in 4-5 and 10-11 year olds

- Kent measured 94% of Reception year children and 93% of Year 6 children in 2011/12, exceeding the 85% national target.
- 22.9% of children measured in Year R were overweight or obese, and 33.3% of children measured in year 6 were overweight or obese. These rates are similar to that for England 22.6% and 33.4% respectively.

The National ambition is to achieve a sustained downward trend in the level of excess weight children by 2020. The rates of obese and overweight children have been consistently around 22-23% in year R and 32-34% in year 6 over the course of the NCMP programme.

Issues, gaps and opportunities

- Nationally there have been concerns over the Leicester Height Measure equipment used to weigh and measure the height of the children which may have led to inconsistencies in the data. The company concerned has issued guidance about not combining pieces of equipment of different manufacture dates and this has been adopted locally.
- There is an unknown effect of academies and schools not participating in the programme.
- There is currently limited engagement with families
- Limited uptake of interventions
- Different delivery models in East and West Kent.

The NCMP programme was established in 2006. At present it is not possible to fully assess the effect of school base interventions and other healthy weight initiatives may have had on the levels of obesity in Kent. This will become possible from 2014 when the programme will have been in existence for 7 years as enabling a cohort review.

What is costs and what we get for the money

The cost of delivering the NCMP is difficult to identify as the service has been delivered as part of a block contract with Kent Community Health Care Trust.

6.0 Obesity and Weight Reduction Services

What the services are?

Services and programmes delivered by Kent Community Health Trust (KCHT) health improvement team and local authorities to support a healthy lifestyle that encourages increased physical activities and healthier diets include:

- Healthy Passport
- Health Walks
- The Exercise Referral Scheme
- MEND- Mind, Exercise, Nutrition & DO IT!
- Bitesize Nutrition Training
- Food Champion Training
- National Childhood Measurement Programme (NCMP)

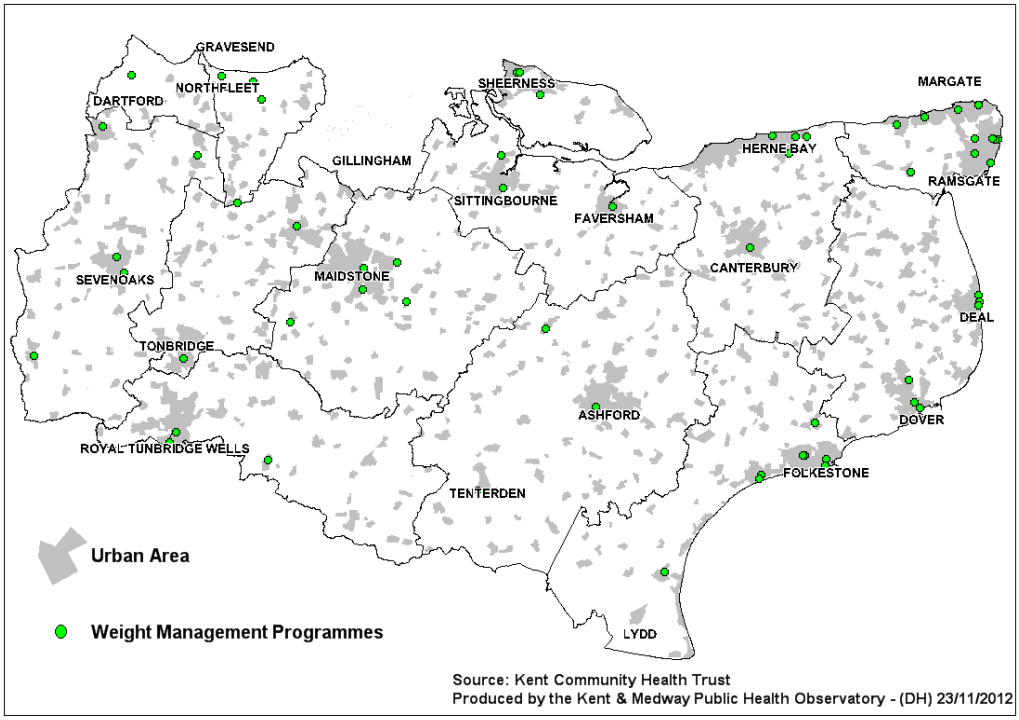
Who is it for?

These services are tiered services, the first tier is for the general population, the second tier are for adults and children between 91st and 98th centile (BMI 25 – 40), the third tier is for people over the 98th centile (BMI > 40) and/or BMI > 35 and having co-morbidities

The contracted provider or providers if there are multiple

Kent Community Health Care Trust is commissioned to deliver the NCMP, Adult's weight management, family weight management, and exercise referral schemes. Local authorities also provide some of the services.

Location of weight management services



National Evidence

- Obesity can be defined as the condition of excess body fat which can lead to health risks such as high blood pressure, sleep apnoea, orthopaedic conditions; and other chronic diseases such as diabetes, heart disease and some types of cancer.
- Body Mass Index (BMI) defined as the weight in kilograms divided by the square of a person's height in meters (kg/m^2) is used to determine overweight and obesity worldwide.
- a BMI greater than or equal to 25 is overweight
- a BMI greater than or equal to 30 is obese
- Obesity reduces life expectancy, by up to 9 years on the average and is estimated to be responsible for more than 9000 premature deaths each year in England.
- In 2010 an estimated 63% of adults in the UK (aged 16 and over) were overweight or obese and 2.5% were morbidly obese (National Obesity Observatory). Kent population mirrors the national picture with over 60% of the population overweight and 28% obese.
- Public Health Outcomes Framework DH 2012
- The Public Health Responsibility Deal DH March 2011
- The Healthy Child Programme :Pregnancy and the first five years of life. Department of Health and DCSF 2009.
- Healthy Child Programme. The Two Year Review. Department of Health and DCSF 2009.
- Healthy Lives Healthy People DH 2010
- Healthy People Healthy lives: A call to action on obesity in England DH 2011
- Healthy Lives, Brighter Futures. DH and DCSF2009.
- Healthy Weight Healthy Lives: A cross government strategy for England
- National Service Framework for Children, Young People and Maternity Services. DH and DfES 2004.
- Maternal and child nutrition NICE guidance 11(NICE 2011)
- Marmot, M (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England*
- *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children NICE CG43 NICE December 2006*
- Preventing Type 2 Diabetes-population and community interventions NICE guidance PH35 May 2011)
- Prevention of cardio-vascular disease NICE guidance PH25 NICE June 2010
- National Obesity Observatory (NOO) for extensive information on policy, research, trend data etc. www.noo.org.uk.

Target and Outcomes

Local performance measures and outcomes are currently being developed.

National Outcome measures

Childhood obesity collated via the National Childhood Measurement programme.

2.6 Excess weight 4-5 and 10-11 year olds

- Kent measured 94% of Reception year children and 93% of Year 6 children in 2011/12, exceeding the 85% national target.

- 22.9% of children measured in Year R were overweight or obese, and 33.3% of children measured in year 6 were overweight or obese. These rates are similar to that for England 22.6% and 33.4% respectively.
- The National Ambition is to achieve a sustained downward trend in the level of excess weight children by 2020. The rates of obese and overweight children have been consistently around 22-23% in year R and 32-34% in year 6 over the course of the NCMP programme.

2.12 Excess weight in adults

- The definition for this indicator is still being developed.

Issues and gaps

- Nationally there have been concerns over the **Leicester Height Measure** equipment used to weight and measure the height of the children which may have led to inconsistencies in the data. **The company concerned has issued guidance about not combining pieces of equipment of different manufacture dates & this has been adopted locally.**
- There is an unknown effect of academies and schools not participating in the programme.
- There is currently limited engagement with families
- Limited uptake of interventions
- Different delivery models in East and West Kent.

The NCMP programme was established in 2006. At present it is not possible to fully assess the effect of school base interventions and other healthy weight initiatives may have had on the levels of obesity in Kent. This will become possible from 2014 when the programme will have been in existence for 7 years as enabling a cohort review.

What is costs and what we get for the money

The weight management services have a budget of £1.94m.

The cost of delivering the NCMP is difficult to identify as the service has been delivered as part of a block contract with Kent Community Health Care Trust.

7.0 Locally Led Nutrition Initiatives

Locally led nutrition services (see also breastfeeding)

A range of holistic initiatives are commissioned from Local Authorities and Kent Community Health Trust (KCHT), based on local community needs. Across Kent fruit and vegetable bag schemes, as well as, healthy cooking courses for children and adults are widely available as part of local schemes. Examples of local initiatives are the Community Chef, Little Stirrers and Fun With Food programmes. The nationally funded 'Let's Get Cooking' has healthy eating at the core of its work – 'let's get cooking' clubs are provided in some schools and there is a Kent wide team that works to improve the health of children and young people in schools and other settings. In addition nutrition is a fundamental component of all Weight Management programmes for adults and families. Weight management programmes are freely available in all localities. Information on these programmes can be found on the 'Active Kent' website at www.activekent.co.uk

Health Trainers engage with individuals on identifying needs and developing personal plans for addressing particular health concerns. Advice relating to nutrition and diet is a part of their skill set. This service is primarily delivered by Kent Community Health Trust but some Healthy Living Centres also have health trainers.

Who is it for?

There are a range of different schemes targeted at different age groups, at families, school and children centre based. The Health Trainer scheme is directed at adults but many adults have children and personal behaviour change is likely to have an influence on the family.

The contracted provider or providers if there are multiple

The main providers are

Kent Community Health Trust (KCHT)
Dartford Borough Council
Gravesham Borough Council
Maidstone Borough Council
Tonbridge and Malling Borough Council
Sevenoaks District Council
Tunbridge Wells Borough Council

NB Most providers also manage contracts with other providers i.e. KCHT manages sub-contracted contracts with pharmacies to deliver healthy weight programmes.

National Evidence

- Public Health Outcomes Framework DH 2012
- The Public Health Responsibility Deal DH March 2011
- The Healthy Child Programme :Pregnancy and the first five years of life. Department of Health and DCSF 2009.
- Healthy Child Programme. The Two Year Review. Department of Health and DCSF 2009.
- Healthy Lives Healthy People DH 2010
- Healthy People Healthy lives: A call to action on obesity in England DH 2011
- Healthy Lives, Brighter Futures. DH and DCSF2009.
- Healthy Weight Healthy Lives: A cross government strategy for England
- National Service Framework for Children, Young People and Maternity Services. DH and DfES

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- Maternal and child nutrition NICE guidance 11(NICE 2011)
- Marmot, M (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England*
- *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children NICE CG43 NICE December 2006*
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- National Obesity Observatory (NOO) for extensive information on policy, research, trend data etc. www.noo.org.uk.

Target and Outcomes

- National Ambitions from the Call to action on obesity:
  - A sustained downward trend in levels of excess weight in children by 202
  - A downward trend in the level of excess weight averaged across adults by 2020
- NICE weight management target 5-10% loss of body weight over 2 years
- DH developing new adult obesity indicator based on Active People survey, including some self-reported metrics

There appears to be some slowing in the National Child Measurement Programme data re: Year R children but levels in Year 6 are increasing. Kent is similar to the national average. However, national results are showing that improvements in more affluent areas not replicated in the less affluent areas may be widening health inequalities.

For both adult obesity and adult healthy eating Kent is significantly worse than the national average (APHO Health Profile for Kent 2012)

Issues, gaps and opportunities

There are currently two models of delivery in Kent. In the west services have been commissioned through each of the district councils under the banner of 'Choosing Health' and in the east services are commissioned through Kent Community Health Trust.

There are different levels of success being achieved through the different models. A review of the different services being provided is being commissioned.

What is costs and what we get for the money

It is not possible to separately identify the funding on these initiatives as they are contained within more general specifications.

7.1 Breastfeeding

What is the service?

Public Health commission a community support service to increase the uptake of breastfeeding. This includes

- generating publicity and media work (including Breastfeeding Awareness Day activities)
- Project Management and Training to support the achievement of UNICEF Baby Friendly Initiative accreditation in all maternity settings and in the community
- Lactation Counsellor support clinics in key areas of need
- Peer Support in hospital and community settings including drop-ins

In addition the Public Health Primary Care Development Team assists with data collection for the 6-8 week target

Who is it for?

It is primarily to support women and their partners – therefore mainly antenatal and postnatal women of childbearing age and their family members.
However, there is a

- wider educational/awareness raising element that has wider coverage to potential parents
- universal community awareness raising role to encourage a culture supportive of breastfeeding

The contracted provider or providers if there are multiple

This specialist service supports maternity units, health visiting services, children's centres and primary care which are contracted elsewhere

The main providers are:

National Childbirth Trust
PSB Breastfeeding
Ingrid Sherwell certified NCT counsellor
Jane Gerard Pearce certified Lactation Specialist

National Evidence

- UNICEF Seven Point plan for Sustaining Breastfeeding in the Community (UNICEF 2008)
- Public Health Outcomes Framework DH 2012
- The Healthy Child Programme (Pregnancy and the first five years of life). Department of Health and DCSF 2009.
- Healthy Child Programme. The Two Year Review. Department of Health and DCSF 2009.
- NICE guidance on antenatal and postnatal care replaced by CG 62 Antenatal Care Routine Care for the Healthy Pregnant Woman 2003 and CG37 Postnatal care: Routine postnatal care of women and their babies 2006
- Healthy Lives Healthy People DH 2010
- Healthy Lives, Brighter Futures. DH and DCSF2009.
- National Service Framework for Children, Young People and Maternity Services. DH and DfES

2004.

- Maternal and child nutrition NICE guidance 11(NICE 2011)
- Midwifery 2020 Programme (2010) The Core Role of the Midwife Work stream
- Tackling health inequalities in infant and maternal health outcomes. Report of the Infant Mortality National Support Team. (DH 2010)
- Marmot, M (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England*

Further useful information is contained on www.ekbaby.nhs.uk (including West Kent support information.)

Target and Outcomes

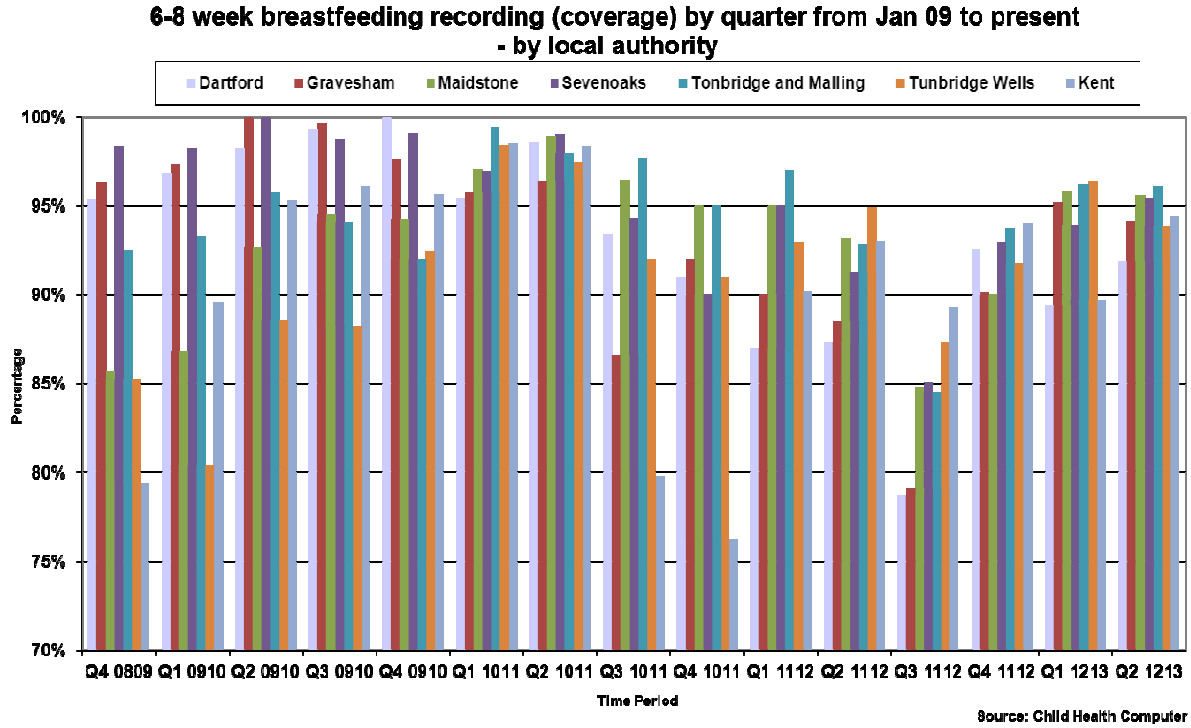
National Outcome Measures
2.2i Breastfeeding Initiation
2.2ii Breastfeeding continuation 6-8 weeks after birth

Initiation (this is a reported by maternity services but if initiation rates are low it impacts on continuation)

Continuation at 6-8 weeks coverage target 95%
Coverage at 6-8 weeks prevalence target was 46% 2011/12 currently none

Meeting the coverage target has been elusive in the West but is now more of a challenge in the East localities. Not achieving the coverage target means that the prevalence data is not robust enough to be published.

Although there was improvement after the targets became vital signs for PCTs the prevalence has not improved much in the last few years.



Issues and gaps

Are there any known issues with the service – is it achieving what we need it to achieve – if not why not and what do we need to do to make it more effective.

This work has been underfunded in the West of the area particularly. Currently there are a number of providers and although they are very committed there is fragmentation. The plan is to tender for a Kent service

What is costs and what we get for the money

Eastern Coastal Kent	£75,000
West Kent	£90,000
Commissioning Intentions (new funding 2012/13)	£150,000
TOTAL Kent	**£315,000**

It is proposed that all the available funding will be spent in year on enhanced local contracts, development and the tender processes. In year 2013/14 it is proposed that:

£215,000 will fund a Kent-wide Infant Feeding Service
£100,000 is used to fund a tongue tie service that is accessible to Dartford, Gravesham and Swanley and West Kent CCG patients.

8.0 Increasing levels of physical activity in the population

What is the service?
The current direct commissioning of physical activity carried out by Public Health is, for the majority, as part of the healthy weight and obesity programmes and this is outlined in the factsheet 6.
Who is it for?
The aim is to increase physical activity within the total population of Kent. This would include working in partnership with schools, community groups and workplaces.
The contracted provider or providers if there are multiple
Public Health and the KCC Sport and Physical Activity Service have worked together for a number of years to support and encourage Kent residents to have more active lifestyles, whether that is through simple recreational activity such as walking or cycling or more formal sporting activity within leisure facilities and sports clubs. This work has also developed as part of the former Local Area Agreement where 'Adult Participation in Sport and Active Recreation' was one of the key indicators within the Kent Agreement. A major component of this work was the development of Active Kent, a campaign linked to the national Change4Life work aimed at promoting physical activity opportunities including sport to people in Kent and under-pinned by the development of a website www.activekent.gov.uk promoting relevant information on opportunities and linking to other local sport and physical activity websites. This website is still operational and is currently updated through a small staffing resource currently located in each of the existing PCTs. However there has been limited promotion of Active Kent in the last year, largely due to the ceasing of the Local Area Agreement but also due to the changes within Public Health.
National Evidence
Nice Pathway **Physical activity overview.** May 2011 **Promoting physical activity for children and young people**. NICE public health guidance 17 (2009) **Physical activity and the environment**. NICE public health guidance 8 (2008) **Promoting physical activity in the workplace**. NICE public health guidance 13 (2008) **Four commonly used methods to increase physical activity.** NICE public health guidance 2 (2006) **Prevention of cardiovascular disease at population level.** Nice public health guidance (2010) **Maternal and child nutrition**. NICE public health guidance 11 (2008) **Obesity**. NICE clinical guidance 43 (2006) **Department of Health** **Start Active, Stay Active. A report on physical activity for health from the four home countries'.** **Chief Medical Officers. London: Department of Health. (2011).**

Sedentary Behaviour and Obesity: Review of Current Evidence. **Department of Health (2010).**
Be Active, Be Healthy: A Plan for Getting the Nation Moving. **Department of Health (2009a).**
Let's Get Moving. A new physical activity care pathway for the NHS, Commissioning Guidance. **Department of Health (2009b).**
Choosing Activity: a physical activity action plan. **Department of Health (2005)**
At least five a week: evidence on the impact of physical activity and its relationship to health. **Department of Health (2004)**

Target and Outcomes

The new Public Health Outcomes Framework (PHOF) clearly identifies several indicators that either specifically reference physical activity (i.e. adult participation in physical activity) or which physical activity can make a contribution to (i.e. obesity levels in children)

National Outcome Measures

1.6 The utilisation of green space for exercise/health reasons

- The percentage of people in Kent using outdoor space for exercise or for health reasons is **13.4%** in Kent similar to that for England **14%**

Issues, Gaps and Opportunities

With the Public Health function and key Public Health staff moving into KCC from April 2013, there is a real opportunity to develop the existing relationship around physical activity. Specifically working KCC Sport and Physical Activity Service and the highways team.

Existing partnership work between Public Health and the Sport & Physical Activity Team includes the development of a new partnership Strategic Framework for Sport & Physical Activity (to build on the success of London 2012), a Public Health representative on the Kent & Medway Sports Board, input to Mind the Gap, the Health Inequalities Action Plan and joint promotion of the Healthy Passport Club.

Similar partnership work exists across the county between Public Health and all the Borough and District Councils, Kent Community Health Trust, Kent Association of Leisure & Cultural Officers, Local Nature Partnerships, Countryside Partnerships, Explore Kent and others

What is costs and what we get for the money

There is no specifically identified budget for increasing the levels of physical activity within the population of Kent. However much of this agenda is delivered in conjunction with and through the healthy weight agenda.

Pockets of investment specifically related to improving physical activity include a contribution from public health of **£5000** in 2012/13 to the "Sky Ride" programme, a partnership campaign led by Sky and KCC Highways "*to inspire the nation and get more people on bikes"* www.goskyride.com A decision has yet to be taken if this funding is to be recurrent or non-current.

9.0 Health Checks

What is the service?
The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce of manage that risk. A high uptake of NHS Health Checks is important to identify early signs of poor health leading for opportunities for early interventions.
Who is it for?
This is a targeted service for the population aged 40 to 74 across Kent.
The contracted provider or providers if there are multiple
Kent Community Health Care Trust (KCHT) has been commissioned to provide this service across Kent. They then sub-contract with GPs, community pharmacies and local authority providers.
National Evidence
Through the Health and Social Care bill NHS Health Checks will be a mandated service for local authorities to provide. Data collected for this indicator provides information of how well the programme is taken up and how accessible it is. National guidance has been produced by the Department of Health: **Vascular Risk Assessment: Workforce Competences** - June 2009 **Best Practice Guidance for the Assessment and Management of Vascular Risk** - April 2009 **Putting prevention first- vascular checks: risk assessment and management - next steps guidance for primary care trusts** - November 2008 **Putting prevention first: Vascular checks risk assessment and management- impact assessment** - November 2008 **Economic modelling for vascular checks** - April 2008 **Putting prevention first - vascular checks: risk assessment and management** - April 2008 Guidance has been provided for clinical commissioning guidance for CCGs The following NICE guidance relates to health checks:

Intervention offered	Existing Guidance
Brief exercise intervention	NICE Guidance PHI002 “Four commonly used methods to increase physical activity”, March 2006
Multi-component weight loss programmes	NICE clinical guideline CG43 “Obesity”, December 2006
IGR intensive lifestyle management	NICE clinical guideline CG43 “Obesity”, December 2006 and Health Technology Assessment 2004; Vol 8: No. 21
Stop Smoking Services	NICE guidance PHI001 “Brief interventions and referral for smoking cessation in primary care and other settings”, March 2006
Anti-hypertensives for those with hypertension	NICE clinical guideline 34 “Management of hypertension in adults in primary care: partial update”, June 2006
Statins for primary prevention	NICE technology appraisal 94 “Statins for the prevention of cardiovascular events”, January 2006

In addition, the following NICE Guidance have been released since the economic analysis was carried out:

Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease - Clinical guidelines, CG67 - Issued: May 2008

Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population - Public health guidance, PH35 - Issued: May 2011

Alcohol-use disorders - preventing the development of hazardous and harmful drinking - Public

health guidance, PH24 - Issued: June 2010

Target and Outcomes

The Health Check programme should be offered to at **least 20%** of the eligible population annually.

National Outcome Measures

2.22i Take up of NHS Health Check Programme by those eligible - health check offered

- Percentage of eligible population aged 40 to 74 offered an NHS Health check in the financial year April 2011 to March 2012 = **7% of eligible population (32,348 people)**

2.22ii Take up of NHS Health Check programme by those eligible - health check take up

- Percentage of eligible population aged 40 to 74 offered an NHS Health Check who received an NHS in the financial year April 2011 to March 2012 = **32.8% of those offered an NHS Health Check (10,602 people)**

Issues and Gaps

The health check programme is a high profile initiative that is being closely scrutinised. It is a mandatory requirement to provide health checks for people between 40 – 74 years, once every five years on a rolling programme, unless identified as at risk when they are called annually. The programme seeks to reduce premature mortality from vascular diseases by reducing the risks of individuals of future events through appropriate treatment. There needs to be sufficient resource allocated to ensure that those who are identified as being at risk are able to access other services such as weight management and physical activity to enable them to change their lifestyles and improve their health and wellbeing.

What is costs and what we get for the money

There has been an investment of **£2.4 million** into the health checks programme. This includes the provision of health checks and the interventions required when someone is identified as being at risk of cardiovascular disease. This includes interventions such as weight management programmes.

10.0 Public Mental Well Being for children and Adults

What is the service? public Mental Well Being for children and Adults

This is not a service - but an array of services and partnerships that seek to ensure that mental well-being is at the heart of all commissioned services.

The two key underpinning theories / approaches are:

1. There is no health without mental health and 5 ways to well-being (connect, learn, move, notice and give)
2. Social connected ness and cohesion. This underpinning theory of well-being is at the heart of tackling social and health inequalities as well as contributing to the Big Society.

There are 8 programmes underway

1 the 5 ways to well-being network:
This is a learning network where key partners including drug and alcohol services, RSA, community health Kent, public health and social services and the voluntary sector develop innovative programmes based on the 5 ways to well-being: examples of these programmes are

- singing for health
- Library and reading for well being
- social connectedness and service access
- time banking and volunteering
- shed programme for men

2 mental well-being impact assessment
This is an internationally validated methodology that assesses and plans interventions based on an impact assessment on a service, policy or intervention. Each borough council in Kent has agreed - as part of a well-being programme and their health inequalities strategy to undertake an impact assessment. Training has been provided by nationally recognised trainers who have developed this tool. In addition the methodology of this tool has influenced the formation of a bespoke inequalities impact assessment that takes into account the psycho social nature of health inequalities (i.e. stress).

3 Time to Change
This is a national anti-stigma campaign for acceptance of mental illness and distress in all aspects of the community. This is led by the engagement officer of the mental health trust and involves all aspects of the mental well-being community.

4 the healthy passport scheme
This is a public health initiative that works on the principle of a social network for health and well-being and encourages physical activity. These are two of the 5 ways to well-being and has had much success in west Kent and is will be rolled out in the east Kent localities. It is linked to Change 4 Life.

5 Kent and Medway suicide prevention strategy
This is a partnership which takes forward audit and action to target reduction of suicide in Kent and Medway. Actions include working with pharmacies re prescriptions and poisoning, signposting advice and information at key hotspots e.g. jumping points and train stations. Working with the

Samaritans and voluntary agencies to provide accessible support and working with mental health providers to improve care planning and bed watching.

6 Live it Well
This is the overarching strategic approach and well-being concept for all commissioned services for mental health. Its aims are to improve services for people with mental illness and enable more with mental illness to live happily in the community supported by primary care. There is a website with a large amount of information and live it well centres. There are also programmes to help people with a diagnosis of mental illness to obtain employment.

7 children's emotional well-being services
There is a £1 million programme of initiatives to support the Children's mental health services to provide well-being and support for families across Kent. This is commissioned jointly by KCC children's and education services and CCGs.

8 community mental health development workers in health improvement and health inequalities. CDW workers are working alongside well-being commissioned services to ensure there is service equity to vulnerable groups. CDWs are working with each district council in east Kent to enable each Council to prioritise 3 actions they will take to improve well-being in vulnerable groups in Kent.

In addition : public health consultants and specialists provide:

- needs assessments
- economic evaluations
- equity audits
- suicide audits
- community development support
- network leadership

To ensure that all services and partnerships are underpinned by the improvement of mental well-being.

Who is it for?

The services are for all of the population of Kent.

The contracted provider or providers if there are multiple

There are a number of providers for mental health services these would include Kent Community Health Care Trust [KCHT], Local Authorities the voluntary sector and pharmacies.
see above

The mental health pathway is outlined below

1. Whole population well-being programmes and support including social connectedness and cohesion initiatives

2. Improving Access to Psychological Therapies (IAPT): this the psychological therapy service in primary care. It is a first point of access and accepts self-referral and GP referral. The provider is KMPT (Kent and Medway Partnership Trust). There are 3 steps, step 1 (moderate needs)' step 2

(increasing needs) and IAPT plus (a more specialised service for more complex cases e.g. eating disorders).

3. Crisis intervention and rapid response to psychosis. These are secondary mental health urgent access services for people who are in acute distress.

4. Community mental health teams: these are specialist services for people who need stable management in the community - they will be given a package of care and then helped to manage in primary care when they are stable. They will work closely with GP services so that if people feel ill again - they can go back to secondary care if needed.

5. Acute hospital care. If people are in danger to their selves or others and need acute observation.

6. Specialist and forensic tertiary treatment services, for very serious and complex needs.

National Evidence

- No health without mental health: A cross-Government mental health outcomes strategy for people of all ages
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123993.pdf

- Delivering better mental health outcomes for people of all ages
  http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124057.pdf

NICE guidance including:

- Promoting mental wellbeing at work
  http://www.nice.org.uk/nicemedia/live/12331/45893/45893.pdf

- Mental wellbeing and older people
  http://guidance.nice.org.uk/PH16/Guidance/pdf/English

- Social and emotional wellbeing in primary education
  http://www.nice.org.uk/nicemedia/live/11948/40117/40117.pdf

- Social and emotional wellbeing in secondary education
  http://www.nice.org.uk/nicemedia/live/11991/45484/45484.pdf
- Social and emotional wellbeing - early years
  http://www.nice.org.uk/nicemedia/live/13941/61149/61149.pdf

- Looked-after children and young people
  http://www.nice.org.uk/nicemedia/live/13244/51173/51173.pdf

- Antenatal and postnatal mental health
  http://www.nice.org.uk/nicemedia/live/11004/30431/30431.pdf

Target and Outcomes

The following indicators from the Public Health Outcomes Framework (PHOF) reflect factors that can have a significant impact on our health, wellbeing and health inequalities:

National Outcome Measures

1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation (2010-2011) - Percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review of multi-disciplinary care planning meeting.

- Kent County Council (KCC) - 68.4% vs. England-66.8% (not compared)

2.08-Emotional well-being of looked after children (2010-2011)- Total average difficulties score for all looked after children aged between 4 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31st March.

- KCC-13.9% vs. England-15.5% (not compared)

2.23i- Self-reported wellbeing- people with a low satisfaction score(2011-2012)- The percentage of respondents scoring 0-6 to the questions "Overall, how satisfied are you with your life nowadays"

- KCC- 21.3% lower than the rate for England-24.3%

2.23ii - Self-reported well-being - people with a low worthwhile score (2011-2012)- The percentage of respondents scoring 0-6 to the questions ”Overall to what extent do you feel the things in your life are worthwhile”

- KCC-15.7% lower than rate for England-20.1%

2.23iii - Self-reported well-being - people with a low happiness score (2011-2012)- The percentage of respondents scoring 0-6 to the questions “ Overall, how happy did you feel yesterday”

- KCC-26.4% lower than rate for England -29.0%

2.23iv - Self-reported well-being - people with a high anxiety score (2011-2012)- The percentage of respondents scoring 4-10 to the questions “Overall how anxious did you feel yesterday”

- KCC-37.8% similar to rate for England-40.1%

4.10- Suicide rate (provisional) (2009-2011)-Age standardised mortality rate from suicide and injury of undetermined intent per 100, 000 population (provisional).

- KCC-7.4% similar to rate for England-7.9%

Data for the following indicators are not available:

1.7- People in prison who have a mental illness or significant mental illness.

1.8- Employment for those with a long-term health condition, including those with a learning difficulty/disability or mental illness.

Issues, gaps and opportunities

Asset mapping: we need to map not only health needs but health assists e.g. libraries and how they can link to GPs to provide good information and support.

We need to equip primary care with the skills and knowledge to support people in the community.

Domestic violence and its impact on well-being is a critical gap regarding a clear commissioning direction.

Steering more mainstream programmes to have an emphasis on mental well-being is time intensive and needs involvement from many partners.

Reorienting the public health commissioned services to all have well-being in the heart of their services is needed e.g. sexual services and lifestyles services.

Workplace health is an opportunity to tackle sickness absence through well-being initiatives.

What is costs and what we get for the money

There is a mapping underway to estimate the costs involved in well-being work. But key costs are

-CDW (Community Development Worker) programme **£550k** approximately
- live it well website and resources **£5k** approximately non-recurring
- healthy passport scheme and health trainers (obesity and weight management services)
- children's emotional well-being programme **£ 1 million** approximately

11.0 Dental Public Health

What is the service?

Local authorities will become responsible for the delivery of dental public health services. These include the following :

- Oral Health promotion programmes.
- Dental inspections of pupils in attendance at schools maintained by local education authorities.
- Oral health surveys and fluoridation.

Who is it for?

The service is for the whole population within Kent based on defined clinical need and indicators of need, but especially for at risk groups -

- people living in areas of material and social deprivation
- Vulnerable groups of society such as those with a learning disability and mental illness
- people in long-term institutional care
- homeless people and
- some refugee and asylum seeker
- People requiring palliative care and people undergoing cancer treatment.
- The elderly

The contracted provider or providers if there are multiple

Kent Community Health Care Trust (KCHT) and Medway Community Healthcare

National Evidence

NICE guidelines, policies etc. – please include links to website and policy documents if available.

- Delivering Better Oral Health provides an evidence base of interventions for prevention of dental diseases in children (Department of Health, 2009) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102982.pdf

- *Delivering Better Oral Health* –An evidence–based toolkit for prevention published on 26 September 2007 (Gateway No. 8504)

- *Valuing People's Oral Health* provides guidance on the development of services for those with a disability (Department of Health, 2007).

- *Dental recall: Recall interval between routine dental examinations* provides guidance on the recall of dental attendance based on individual risk (NICE, 2004)

- The good practice guidance *Choosing Better Oral Health* – an Oral Health Plan for England

published on 14 November 2005

- NHS Dental Epidemiology Programme for England Oral Health http://www.nwph.net/dentalhealth/reports/Report_NHS_DEP_for_England_OH_Survey_12yr_2008-09.pdf

Target and Outcomes

23.5% of 5-year-olds and 23.6% of 12-year-olds in Kent and Medway were estimated to have experience of tooth decay in the national dental health surveys of 5 and 12-year-olds carried out in 2007/08 and 2008/09. This is lower in prevalence compared to the regional and national average.

Target: Reduction of dental caries in 5 year-old children, which is one of the Public Health Outcomes Indicators

NHS Medway has no immediate plans for the fluoridation of the water supplies.

Issues, gaps and Opportunities

Opportunities

- The Primary Care Trust has commissioned a number of Oral Health Promotion programmes in addition to the NHS epidemiology programme through the Salaried Dental Service. In 2011-2012 they carried out the survey of 5-year-old children and next year 2012-2013 will be undertaking a survey of 3-year-old children.

- Oral health in children and adults has been recognised in the Joint Strategic Needs Assessment and dental public health services will be important in the delivery of the Joint Health and Wellbeing Strategy.

Gaps

- Geographical inequality in uptake of primary care dental services
- Geographical inequality in commissioned activity per population
- Lack of local data on dental health. National surveys provide data at the SHA level.
- The need for specialist dental services needs to be reviewed.

Recommendations for consideration by commissioners

- Promote orientation of primary care dental services to focus on effective health promotion and prevention of oral disease in line with ***Delivering Better Oral Health – a toolkit for prevention*** **(Department of Health, 2009)**
- Improving uptake of services by local residents through ensuring availability of accessible services and provision of information to support uptake Improving access to specialist services
- Promote development of an appropriate skills-mix workforce in order to meet the dental needs of the population effectively and efficiently
- Develop oral health promotion initiatives for the elderly and other vulnerable adult groups

• Robust, annual monitoring and evaluation of dental practices • Improve children's oral health to give them a chance of keeping good oral health throughout their lives.
What is costs and what we get for the money
The current expenditure is £132,041

12.0 Accidents and Injury Prevention

What is the service?

No specific service is being commissioned by Public Health. Most of our input is consultation and advice to CCGs and social care.

Who is it for?

It is important to distinguish the causes and risks of accidents and injuries by age group and they will differ for under-15yrs, working age and the frail elderly.

- Injuries in working age should be covered in detail under workplace health.
- For under 15s the recommendations are broadly divided into 3 areas by NICE – unintentional injuries, improving road design for land transport injuries and improving safety at home.
- For the frail elderly, the recommendations fall broadly under prevention of falls and fracture using an integrated targeted approach involving liaison services based in primary care, community care and acute care and more importantly targeted community based therapeutic exercise programmes and the use of assistive telecare devices such as fall alarms.

The contracted provider or providers if there are multiple

Advice is for commissioners and providers of health services, local authority children's services, local authorities and their strategic partnerships, local highway authorities, local safeguarding children boards, police, fire and rescue services, policy makers, professional bodies, providers of play and leisure facilities, and schools.

National Evidence

NICE Guidance
Strategies to prevent unintentional injuries among under-15s (PH29)
Preventing unintentional road injuries among under-15s: road design (PH31)
Preventing unintentional injuries among under-15s in the home (PH30)
http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7280#/search/?reload

Falls and Fractures: Effective Interventions in Health and Social Care
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103146

Other policy documents
The Role of Public Health in Injury Prevention
http://www.injuryobservatory.net/documents/Policy_briefing_1.pdf
Developing a national policy for prevention
http://www.injuryobservatory.net/documents/Policy_briefing_2.pdf
Kent Children's JSNA 2011 http://www.kmpho.nhs.uk/population-groups/children/jsna-2011/
Child Accident Prevention Trust www.capt.org,uk

Target and Outcomes

- South West Public Health Observatory is currently the lead for describing injury rates across England by district authority.
- Tunbridge Wells DA area is rated relatively high among others in terms of land transport injuries and injury under 5s although the numbers are small and over 3 years.
- There has been approximately 50% increase in falls and fractures related hospital admissions in the 65 and above population in Kent (including relatively high rates of hip fracture

admissions) over the last 5 years, compared to an 11% increase in population in the same age group.

National Outcome Measures

Falls

- Injuries due to a falls in all people aged 65+, Kent 1680 per 100,000 similar to England 1642 per 100,00
- Injuries due to a fall in males aged 65+, Kent 1272 per 100,000, similar to England 1269 per 100,000
- Injuries due to a fall in females aged 65+, Kent 2088 per 100,000 higher than England 4711 per 100,00
- Injuries due to fall in people aged 65-79 (2010/11), Kent 884 per 100,000, lower than England 959 per 100,000
- Injuries due to falls in people aged 80+ (2010/11), Kent 5260 per 100,000, higher than England 4711 per 100,000

Road Traffic Collisions

- Killed and seriously injured causalities on England roads 2009-11, Kent 39.5 per 100,000, lower than England 42.2 per 100,000

The acute trusts are required to participate in the national falls audit. Assessing quality and standards of related services.

Issues and gaps

Under unintentional injuries the issues covered are:

- Planning and coordinating local activities.
- Workforce training and capacity building through national standards and curricula.
- Injury surveillance to monitor the incidence of unintentional injuries among under-15s and plan preventive initiatives.
- Fitting permanent safety equipment and carrying out home safety assessments
- Outdoor play and leisure, including policies to ensure public play spaces are safe, and education and advice on water and firework safety.
- Road safety, including strategies to help reduce vehicle speed in areas near where children and young people are present and managing road safety partnerships.

Under road design and safety the issues cover 20 mph limits, 20mph zones and engineering measures to reduce speed or make routes safer. Advice is on particularly:

- How health professionals and local highways authorities can coordinate work to make the road environment safer.
- Introducing engineering measures to reduce vehicle speeds, in line with Department for Transport guidance.
- Making routes commonly used by children and young people safer. This includes routes to schools and parks.

Under home safety the issues are:

- Prioritise households at greatest risk
- Establish partnerships with local community organisations offer home safety assessments and advice
- offer appropriate safety equipment including door guards, cupboard locks, safety gates, smoke and carbon monoxide alarms, thermostatic mixing valves and window restrictors.

Under falls and fracture prevention in the elderly there are main objectives to consider:
Objective 1: Improve patient outcomes and improve efficiency of care after hip fractures through compliance with core standards.
Objective 2: Respond to a first fracture and prevent the second – through fracture liaison services in acute and primary care settings.
Objective 3: Early intervention to restore independence – through falls care pathways, linking acute and urgent care services to secondary prevention of further falls and injuries.
Objective 4: Prevent frailty, promote bone health and reduce accidents – through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards.

Implementation of falls and fracture prevention needs to be part of the wider health and social care integration agenda targeting the complex frail elderly who also suffer from multiple long term conditions including dementia and may be in end of life stage.

What is costs and what we get for the money

There is no specified budget for accident and injury prevention

13.0 Population level interventions to reduce and prevent birth defects

What is the service?

The National Antenatal Screening service and at a local level the Public Health role is to give consultant advice. Occasionally we can be asked to work with national agencies (e.g. Small Area Statistics Unit) to investigate unusual clusters of cases in Kent where an environmental cause is suspected and cascade necessary lay information as part of a risk communication strategy.

Who is it for?

Birth defects occur before a baby is born and range widely. Most birth defects are thought to be caused by a complex mix of factors. These factors include genetics, physical factors such as lifestyle and environmental factors including chemicals. Major birth defect abnormalities can lead to developmental or physical disabilities and babies may also require medical or surgical treatment.
In England there is a national Fetal Anomaly Screening Programme which is offered to all pregnant women and screens for certain conditions such as Down's syndrome. Pregnant women are also offered screening for infectious diseases such as rubella and syphilis. If the mother is infected during early pregnancy, rubella carries a high risk for birth defects.

New born babies are also offered New Born Blood Spot screening identifies babies who may have rare but serious conditions such as Congenital Hypothyroidism (CHT).

The contracted provider or providers if there are multiple

Services for identifying birth defects are commissioned as part of the maternity care across Kent. This will involve mainly health care providers across primary, community and acute care services. .

National Evidence

There is a significant overlap and evidence base for the prevention of birth defects with:

- National Fetal Anomaly Screening Programme

http://fetalanomaly.screening.nhs.uk/

- Good antenatal care as recommended in NICE Guidance

http://guidance.nice.org.uk/CG62

- Healthy Start programme on vitamins and healthy eating in pregnancy

http://www.healthystart.nhs.uk/food-and-health-tips/vitamins/
http://www.healthystart.nhs.uk/food-and-health-tips/healthy-eating-in-pregnancy/

Target and Outcomes

Kent has antenatal care services available in primary care and more specialised care in the hospitals. The National Screening Committee sets standards for the fetal anomaly screening and these are regularly monitored. In Kent we also have a smoking cessation services for pregnant women.

Issues and gaps
From April 2013 commissioning responsibility for the National Screening Programmes will be with the National Commissioning Board. However the Director of Public Health will continue to have an assurance responsibility at a population level, and this will require clear and robust communication links with the Head of Public Health in the National Commissioning Board. Birth defects resulting from lifestyle factors such smoking and alcohol abuse are largely preventable and need timely interventions. There is an on-going need for maternity care providers to support women for changing modifiable risk factors such as giving up smoking and adhere to guidance on alcohol consumption during pregnancy.
What is costs and what we get for the money
N/A

14.0 Behavioural lifestyle campaigns to prevent cancer and long-term conditions

Behaviour and lifestyle campaigns are consider to be an integral part of any public health prevention programme. Much of this work would be undertaken through the healthy weight, physical activity, smoking, mental health and well-being, drug and alcohol and sexual health programmes.

15.0 Workplace Health

What is the service?

In England, there is not a national government backed scheme, although the Workplace Wellbeing charter developed by Liverpool PCT is recognised as a particularly effective model that could be rolled out in other parts of the country. http://www.wellbeingcharter.org.uk/

It is a set of entirely voluntary workplace standards to promote good, safe and healthy work. It provides a framework of good practice standards for managing and promoting health and well-being in the workplace to deliver improved business and health outcomes. The Charter is primarily a business engagement vehicle to encourage and support employers and employees towards a healthy workplaces and healthier lifestyles thereby reducing the risks of uncompetitive high absence costs and low productivity rates for businesses. It provides a simple, structured way to establish organisations' strengths and weaknesses in terms of health and wellbeing, and ways to move forward. The standards are grouped into eight areas of activity. These include;

- mental health and wellbeing
- healthy eating
- physical activity
- smoking and tobacco related ill-health
- alcohol and substance misuse
- health and safety requirements
- leadership
- attendance management.

It is proposed that the Workplace Wellbeing Charter is launched in Kent 2013, which will enable employers to show their commitment to the health and well-being of their employees.

Who is it for?

The guidance will be for employers and professionals in small, medium and large organisations who have a direct or indirect responsibility for improving health in the workplace.

The contracted provider or providers if there are multiple

There are currently no specific providers. The role of public health and KCC will be to help facilitate workplace health within KCC and in other organisations.

National Evidence

- NICE have produced a local government briefing paper specifically on workplace health. It highlights that Local authorities can improve workplace health in two ways – in their own role as an employer, and also by encouraging and helping other employers to improve the health of their employees. The paper makes a series of evidenced based recommendations that employers can utilise around improving specific aspects of health and lifestyle. **http://publications.nice.org.uk/workplace-health-phb2**

- The Workplace (Health, Safety and Welfare) Regulations 1992 http://www.legislation.gov.uk/uksi/1992/3004/contents/made

- A healthy workforce is productive and has wider benefits for the local and national economy. (Black, C. (2008), *Working for a Healthier Tomorrow*, London: The Stationery Office) Staff productivity increases if sufficient resources are invested in staff wellbeing.
- Major Health issues, sickness leave and accidents at work are likely to reduce if employees become more physically active (Dishman et al, 1998)
- Involving your workforce in health and safety: Good practice for all workplaces http://www.hse.gov.uk/pubns/priced/hsg263.pdf

Target and Outcomes

Indicators and outcome measures will be developed as part of the programme.

Issues, gaps and Opportunities

Are there any known issues with the service – is it achieving what we need it to achieve – if not why not and what do we need to do to make it more effective.

Mapping of what is available to employers to improve the wellbeing of their staff is needed.

What is costs and what we get for the money

16.0 Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes

The Director of Public Health needs to have systems in place to ensure that NHS commissioning board (NHSCB) and the clinical commissioning groups (CCGs) and others are accountable for making the appropriate use of any advice given by public health

17.0 Sexual Health Services

What is the service?

Local authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) treatment services.

The sexual health service for Kent includes the following services

- CASH (Contraceptive and Sexual Health Services) – 37 clinics
- GUM (Genitourinary medicine including HIV)
- EHC (Emergency Hormone Contraception) schemes through pharmacies – 130 services
- School based sexual health clinics
- C-Card (condom registration and access points) – 222 services
- TOP (termination of pregnancy) services
- Outreach work

Who is it for?

These services are for the benefit of all persons of all ages within Kent.

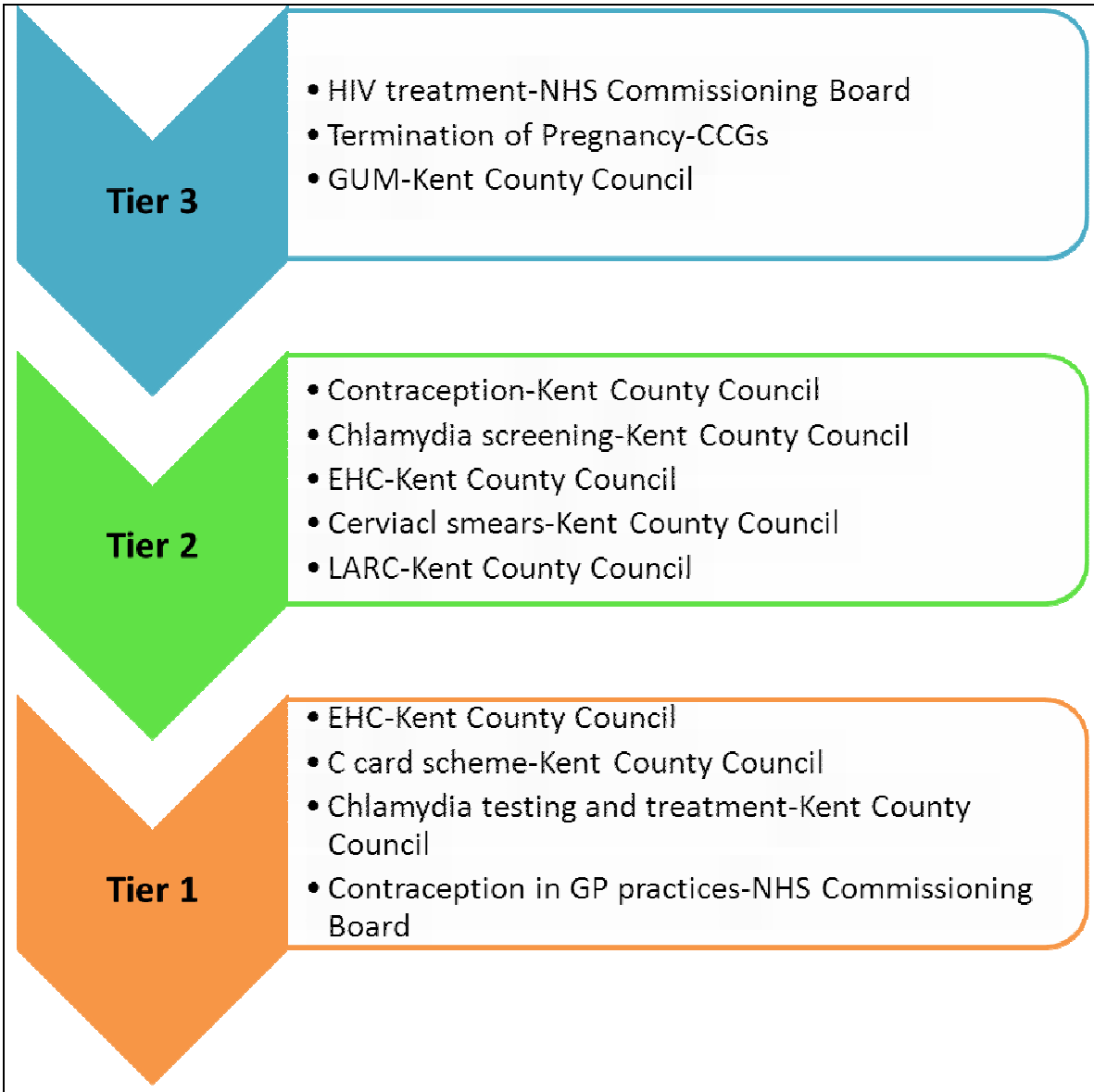
The contracted providers or providers if there are multiple

There are a number of providers commissioned for sexual health services across Kent.

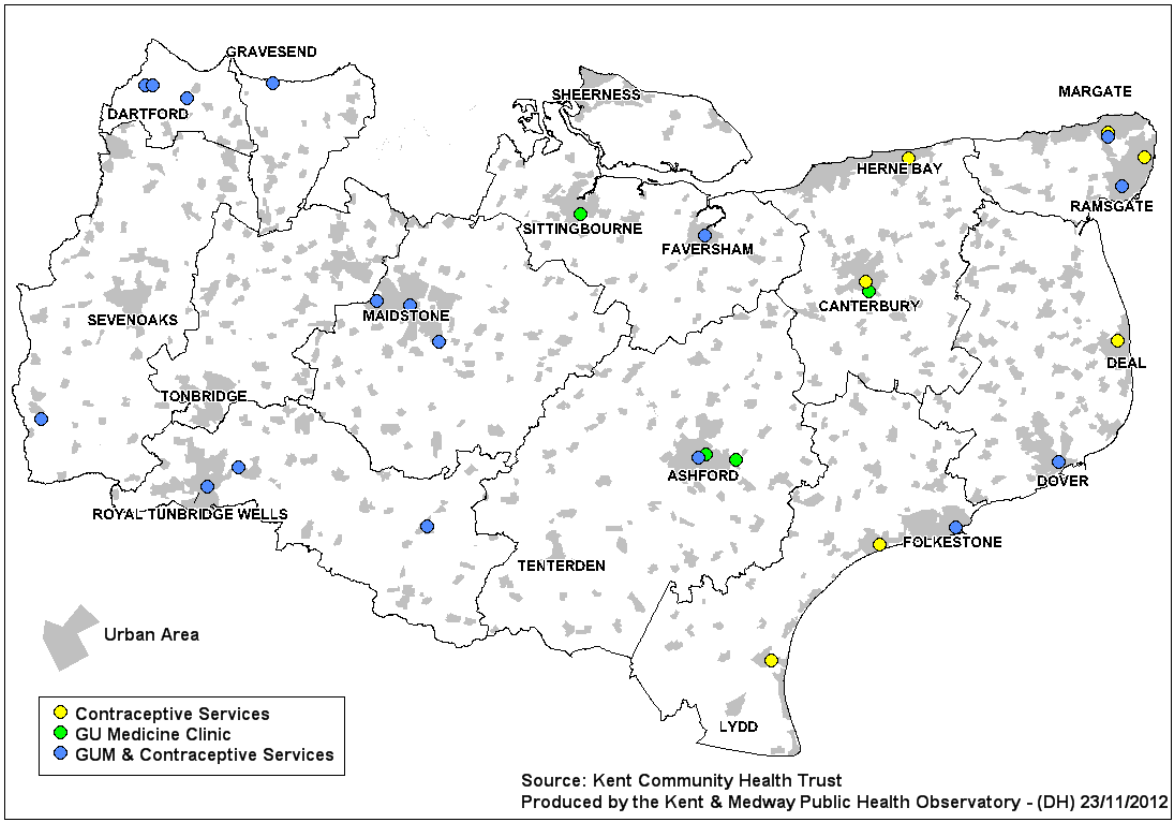
Darent Valley Hospital (DVH)	£950,171
Maidstone and Tunbridge Wells NHS Trust (MTW)	£1,369,781
Medway Foundation Trust (MFT)	£570,781
East Kent Hospitals University Foundation Trust (EKHUFT)	£248,927
Kent Community Healthcare Trust (KCHT)	£9,500,000
Total	£13,513,736

- All the CASH clinics in West Kent and East Kent are provided by Kent Community Health Trust.
- Contracts are all 1 year with 6 month's notice

Sexual health services are commissioned at the following levels



This map below shows the location of the CASH [Contraceptive and Sexual Health Clinics] and the GUM [Genitourinary medicine] services.



National Evidence

- Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV. DoH, July 2001-Refreshed 2008 by the Independent Advisory Group for Sexual Health (http://www.dh.gov.uk/assetRoot/04/07/44/86/04074486.pdf)

- Choosing health: Making healthier choices easier. Department of Health, 16/11/04, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550
- *UK National Guidelines for HIV Testing 2008*
- www.bhiva.org

- MEDFASH Recommended Standards for Sexual Health Services 2005, and MEDFASH Recommended Standards for HIV Services 2004 http://www.medfash.org.uk?

- HIV in Primary Care 2004 http://www.medfash.org.uk?

- NICE guidance Prevention of sexually transmitted infections and under 18 conceptions 2007 - http://www.nice.org.uk/PHI003?

Target and Outcomes

National Outcome Measure

3.2 Chlamydia diagnosis (15-24 year olds)

3.4 People presenting with HIV at a late stage of infection

Sexual Health Targets

- 48 hour access to GUM services – 100%
- Chlamydia diagnosis 15 -24 year olds

- Chlamydia screening is recommended for all sexually active people under 25, annually and on partner change.
- The Health Protection Agency (HPA) recommends that local authorities should be working towards achieving a diagnosis rate of at least 2,400 per 100,000(2.4%) population

For Kent this would mean diagnosing approximately **4,414** 15 to 24 year olds. Public Health Outcomes Framework baseline 2010 was **1,562** diagnoses per 100,000 population 15 to 24 years.

- Late diagnosis of HIV is defined as a CD4 count of less than 350. Late diagnosis has been mentioned in the Public Health Outcomes Framework but it hasn't been decided nationally what the target will actually look like

Issues , Gaps and Opportunities

- HIV commissioning will be the responsibility of the National Commissioning Board (NCB)
- GUM and CASH services will be the responsibility of Local Authorities
- Termination of pregnancy will be the responsibility of Clinical Commissioning Groups.

The challenge will be to ensure that the population of Kent receives the best sexual health outcomes in a consistent and equitable way.

GUM attendances are increasing yearly. We need to cap costs as the increase can no longer be funded within NHS contracts.

DVH have given notice that they no longer want to provide GUM services. This is an opportunity to review the strategic direction of sexual health services in West Kent, focus on transformation of young people services alongside youth services and develop community based services.

What is costs and what we get for the money

The sexual health budget is estimated to be £13,760,308.
This money pays for the provision of sexual health services detailed above.

18.0 Excess Winter Deaths

What is the service?

Excess winter deaths highlight the extent to which there is a higher proportion of the population dying between December and March in relation to the other months of the year. The key public health issue is that excess winter deaths are preventable. The country in Europe with the lowest excess winter death ratio is Finland, yet it has one of the coldest climates.

Exposure to cold temperatures can have a number of health effects that include an increase blood pressure, an increase in the blood's tendency to clot which can increase the risk of coronary thrombosis and stroke and a narrowing of the lung airways producing phlegm and making breathing more difficult. The group of people that are most vulnerable to poor health due to cold temperatures are those aged over 70 years old with underlying coronary heart or respiratory disease.

The Winter Intervention Support Programme Kent (WISK) offers support people at risk of poor health due to cold temperatures.

Services delivered:
The WISK programme involves people at risk being offered a home visit through the Home Improvement Agency. The visits determine what support people need, increase the persons' awareness of the risks of living in a cold environment. The visit also involves signposting to other agencies, identifying trip hazards, installing equipment such as grab rails to reduce the risk of falls, advice on energy efficiency measures, draught reduction, benefit support checks, energy tariff checks, loft insulation level checks, undertake loft clearance to enable insulation, providing smoke detectors and provision of emergency salt matting to reduce the risk of falls. Another key function of the visits is to ensure that home repairs are made to prevent cold conditions (i.e. repairing a broken window or boiler). Telecare in the form of cold weather alarms will also be piloted to some of those that receive a home visit.

Age UK will offer support to people at risk during extreme cold temperatures that will minimise the need for people to go outside unsupported. This will include arranging for the delivery of hot meals, shopping, collecting medicines during cold weather, transporting and accompanying people to medical appointments. They will deliver this function set up a register/team of volunteers/bank staff who will respond to referrals from HIA's. Some individuals may need a number of visits if the weather is particularly cold.

The Kent Health and Affordable Warmth Group is the strategic group that oversees the issue of reducing excess winter deaths.

Who is it for?

The WISK programme will focus on the people that are most vulnerable to poor health due to cold temperatures. These are those aged over 70 years old with underlying coronary heart or respiratory disease.

The contracted provider or providers if there are multiple

There are two Home Improvement agencies in Kent. The In Touch Home Improvement Agency provides the service for the entire county with the exception of Swale.

Swale Borough Council provides the Home Improvement Agency service for the Swale area.

Age UK will provide emergency support to vulnerable people when the weather is particularly cold. One of the locality chief officers for Age UK is leading on the winter warmth support on behalf of all of the chief officers in Kent.

National Evidence

National policies introduced by government to reduce seasonal mortality include winter fuel payments (Directgov, 2011), and the seasonal flu vaccination programme (NHS Choices, 2011).

The Department of Health have published the Cold Weather Plan for England 2012, to reduce the health impact of severe winter weather by alerting health and social care services when severe winter weather is forecast (Department of Health, 2012).
https://www.wp.dh.gov.uk/publications/files/2012/10/9211-TSO-NHS-Cold-Weather-Plan_Accessible-main-doc.pdf

Target and Outcomes

National Outcome Measures
4.15 Excess winter deaths

Local Measures

- To gain insight as to what is most effective in terms of what is most effective and can be utilised for future winter programmes.
- Ensure that a maximum number of people receive support who are at risk of poor health due to cold temperatures in the coming winter.

Issues, Gaps and Opportunities

- There is a service gap between primary care and those able to offer support to the people most vulnerable from poor health outcomes due to cold temperatures. Work with local integrated teams to establish if they can be involved in identifying people who are greatest risk for further support.
- The programme for this winter offers the opportunity to establish what works well and can utilised for future winter programmes.
- Learning from what is effective in other parts of the country should be utilised.

What is costs and what we get for the money

Kent County Council has been successful in obtaining additional funding of £315,000 from the Department of Health Warm Homes Healthy People fund for the coming winter. There is also an underspend of 250,000 from last years' programme that the Department of Health have agreed can be rolled over for this winters programme. These funds can offer targeted support for up to 1,200 vulnerable people across the county this winter.

19.0 The local authority role in dealing with health protection incidents, outbreaks and emergencies

Emergency planning
Directors of Public Health acting on behalf of the local authority will have a pivotal place in protecting the health of its population. Under this duty, local authorities and Directors of Public Health on their behalf will be required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full scale emergencies, and to prevent as far as possible those threats arising in the first place.

Directors of Public Health will also need to ensure that there are local plans for immunisations
Director of Public Health will advise on whether immunisations programmes in the area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS commissioning Board on its performance through the JSNA and discussions at the health and wellbeing board on issues such as raising uptake of immunisations and how outcomes might be improved by addressing local factors. They will also have a role in championing immunisation, using their relationships with local clinicians and CCG and in contributing to the management of serious incidents. Directors of Public Health will play a role in ensuring that immunisation care pathways for programmes such as neonatal hepatitis B are robust. The Director of Public Health will need to ensure that the CCGs respond appropriately to any challenges from the local public health teams and make any improvements where required.

There is also an expectation that under the duty of protecting the health of its population the Directors of Public Health will ensure that local plans exist for screening programmes
Director of Public Health will advise on whether screening programmes in the area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS commissioning Board on its performance through the JSNA and discussions at the health and wellbeing board on issues such as raising uptake of screening and how outcomes might be improved by addressing local factors. They will also have a role in championing screening, using their relationships with local clinicians and CCG and in contributing to the management of serious incidents. Directors of Public Health will play a role in ensuring that screening care pathways for programmes such as the antenatal screening are robust. The Director of Public Health will need to ensure that the CCGs respond appropriately to any challenges from the local public health teams and make any improvements where required.

Infection control
Acute providers will be required to produce plans for prevention and control of infection, including those which are healthcare related. It is the responsibility of the Director of Public Health to ensure these plans exist and are robust.

20.0 Public health aspects of promotion of community safety, violence prevention and response

The Director of Public Health will be expected to work closely with the Police and Crime Commissioner to commission services based on health and social are needs. Public health contributes to the strategic assessments used by Crime and safety partnerships

Public Health will be working with partners on the following agendas

- Alcohol licensing
- Domestic violence
- Road Safety / Accident prevention
- Reducing anti-social behaviour

21.0 Public health aspects of local initiatives to tackle social exclusion

Public health will be working with partners on the following agendas

- **Margate Taskforce**
- **Gypsy and Travelers Needs Assessment**
- **Connecting Communities**
- **Health needs of offenders with community based sentences working with Kent Probation.**

22.0 Needs assessment and commissioning advice to CCGs

The Director of Public Health needs to have systems in place to ensure that NHS commissioning board (NHSCB) and the clinical commissioning groups (CCGs) and others are accountable for making the appropriate use of any advice given by public health

Public health is required to support CCGs in commissioning population health services. Guidance suggests that this would equate to 40% of a suitably qualified public health specialist time.

Public health will support all stages of 'commissioning cycle' from needs assessments and strategic planning to monitoring and evaluation of services. A memorandum of understanding in currently being finalized, this will be discussed and agreed with the Clinical Commissioning Group Leads.

The proposed services and products are listed below

- Joint Strategic Needs Assessment at a local level and support for development of local delivery plans for the Kent Health and Well-being strategy
- Stakeholder engagement for the development and delivery of the local health and wellbeing strategy
- Needs assessment – topics to be agreed and prioritised with CCGs
- Health Equity Audit
- Contributing towards strategic planning
- Health Impact Assessment
- Population profiling and projections for future health care planning
- Monitoring of Public Health Outcomes
- Provision of specialist public health input into the development, analysis and interpretation of health related data sets including the determinants of health monitoring of patterns of disease and mortality
- Support to CCGs on interpreting and understanding data on clinical variation in both primary and secondary care
- Health economic analysis and a population perspective. Interpreting and developing tools to identify return on investment.
- Provide evidence based expert advice for commissioning and decommissioning of services.
- Working alongside CCGs in order to commission health improvement programnmes that dovetail with local clinical pathways
- Ensure CCGs are aware of outcomes being delivered by PH commissioned programmes.

23.0 Needs assessment and commissioning advice to National Commissioning Board

The Director of Public Health needs to have systems in place to ensure that NHS commissioning board (NHSCB) and the clinical commissioning groups (CCGs) and others are accountable for making the appropriate use of any advice given by public health

Screening and immunisation will be the remit of Public Health England and will be delivered at a regional level with staff being seconded from PHE to the NCB Local team.

The Child Health Record System will be commissioned by the NCB this may have implications on how data for Breastfeeding and childhood obesity are accessed.

The areas that need to be negotiated with NCB are

Pharmaceutical Needs Assessment
Public Health within the local authorities will have the statutory duty to undertake Pharmaceutical Needs Assessments with support from the NCB Local Team**.** However the national pharmaceutical services contract of community pharmacies will be administered by the NCB Local Team.

Health needs of Offenders [see page 57]
Veteran Health
Specialised commissioning

Offender Health

The offender population in Kent is relatively large compared to other counties outside London due to the large number of prisons and detention centres in Kent, the demography and size of Kent. Offenders often fall into two broad categories, those "career criminals" who often run large cartels and are generally well organised and "chaotic" offenders (often drug related) and are likely to have many health and social care problems (many were vulnerable children). This second group are also more likely to be both victims and perpetrators and the key public health outcome linked to this group is: **reducing reoffending.**

The public health services that the NHS CB will commission directly are:

- the national immunisation programmes.
- the national screening programmes.
- public health services for offenders in custody.
- sexual assault referral centers.
- public health services for children aged 0-5 years (including health visiting, family
- nurse partnerships and much of the healthy child programme).
- child health information systems.
- Work is also in hand on developing single operating models for the commissioning of offender.
- health, military health, and specialised services.

The NHS CB has stated that more detailed information on individual work areas will be added as it becomes available.

Future Transfer to NHS Commissioning Board

The Health and Social Care Act 2012 places a strategic duty on the NHS Commissioning Board to commission 'services or facilities for persons who are detained in a prison or other accommodation of a prescribed description.' This includes:

Prisons

Police Custody Suites

Immigration Removal Centres

Secure Children's Homes

Secure training Centres

SARC

Forensic Mental Health

In the case of Kent this will be commissioned at the NHS CB local area team (LAT) level in the future which will be one the three lead LATs in the South of England for Offender Health the others being, Thames Valley and Bristol, North Somerset, South Gloucestershire and

Somerset. The Kent & Medway LAT will also commission across Surrey and Sussex for these offender populations.

Services to be commissioned include primary care and mental health services as well as secondary care. The 2012 Act specifically excluded offender secondary healthcare from CCG commissioning.

Kent County Council will have responsibility for health improvement supported by the Director of Public Health and a ring fenced budget. Local NHS CB primary care commissioners will need to work closely with public health colleagues in two main ways:

• firstly, in supporting local authorities, where appropriate, in commissioning health improvement services, some of which could be provided through primary care both in the community and in the criminal justice system and

• secondly, through the advice and expertise that public health colleagues will provide to local area teams on how to commission primary care services in ways that best improve local offender population health and reduce inequalities.

The operating models for prison and offender health, military health and those public health services commissioned by the NHSCB (i.e. screening, vaccinations, child health for 0-5 year olds and public health for people in prisons) have yet to be published and each will have some implications for primary care commissioning arrangements.

The NHS CB are particularly interested in any models of commissioning support, relationships being established with health and wellbeing boards and how public health commissioning relationships might best work.

commissioning KCC services for offenders and crime safety.

- offenders in prison : health commissioned via NCB and PHE (screening)
- offenders in community: probation services, ccg commissioning for primary care and mental health, KCC re substance misuse services and victim based services. ALSO rehabilitative services via probation but also including services for well-being.